FIFTH IN SERIES ON MEDICARE REFORM: STRENGTHENING MEDICARE: MODERNIZING BENEFICIARY COST SHARING

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

MAY 9, 2001

Serial No. 107–21

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

74–223 WASHINGTON : 2001

For sale by the Superintendent of Documents, U.S. Government Printing Office
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FIFTH IN SERIES ON MEDICARE REFORM: STRENGTHENING MEDICARE: MODERNIZING BENEFICIARY COST SHARING

WEDNESDAY, MAY 9, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:11 p.m., in room 1100 Longworth House Office Building, Hon. Nancy Johnson (Chairwoman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 2, 2001
HL–7

CONTACT: (202) 225–3943

Johnson Announces Fifth Subcommittee Hearing in Series on Strengthening Medicare: Modernizing Beneficiary Cost Sharing

Congresswoman Nancy L. Johnson (R–CT), Chairwoman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on beneficiary cost sharing. **The hearing will take place on Wednesday, May 9, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include program experts on beneficiary cost sharing under the Medicare benefit and Medigap insurance coverage. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The structure of Medicare beneficiary cost sharing in the fee-for-service program reflects the insurance practices at the inception of the Medicare program in 1965. As such, more than 35 years later, beneficiaries are confronted with irrational and confusing cost-sharing which does not reflect the current delivery of health care.

For example, the program has two different deductibles—a $792 deductible for Part A and a $100 deductible for Part B. This means that when a beneficiary is hospitalized for an in-patient procedure and less likely to be sensitive to pricing issues, the beneficiary is faced with a significant deductible. In addition, after a beneficiary has been hospitalized for 60 days, the beneficiary must then pay $198 coinsurance per day for days 61 through 90. There is a separate $100 Part B deductible for out-patient procedures, which is arguably more discretionary, never having been indexed to inflation.

Unlike 97 percent of private health policies, the Medicare fee-for-service program still lacks catastrophic insurance protection for those with serious health conditions. Medicare Part B, which is financed 25 percent from beneficiary premiums—about $50 per month—and 75 percent from the General Fund, has unlimited beneficiary cost-sharing. Part B has different coinsurance depending on the service—none for lab or home health, 20 percent for physician services and supplies, and close to 50 percent for hospital outpatient services.

In total, due to cost-sharing obligations and Medicare's limited benefit package, nearly half of seniors' health care costs are not covered by Medicare. As a result, 90 percent of beneficiaries have some type of supplemental coverage. Those with retiree coverage from their former employers generally receive generous benefits, including catastrophic protection and good prescription drug coverage. The poorest beneficiaries receive wrap-around coverage through Medicaid.

Medicare's confusing and irrational cost-sharing has also induced 29 percent of beneficiaries to purchase Medigap insurance. In 1990, Congress created 10 standardized Medigap policies. Nine out of 10 of those policies, which comprise more than

90 percent of the Medigap market, are required to cover the Part A deductible, and the most popular Medigap policy covers both deductibles. Numerous studies have demonstrated that covering the deductibles has led to markedly higher Medicare spending because beneficiaries become insensitive to costs. In addition, only the three most expensive Medigap plans cover prescription drugs, and that coverage is limited. Yet, eight of the 10 plans are required to cover foreign travel insurance, while most beneficiaries never leave the country.

In announcing the hearing, Chairwoman Johnson stated: "A critical element of strengthening Medicare is modernizing the fee-for-service program's byzantine cost-sharing structure. No one designing a seniors' health program today would construct such a convoluted and irrational cost-sharing structure for beneficiaries. The system is a patchwork of outdated policies that fail to protect beneficiaries or taxpayers. We must learn from our experience and work to ensure a more consistent and understandable system for the future."

FOCUS OF THE HEARING:

The hearing's panel will include private and public experts on the Medicare fee-for-service program's beneficiary cost sharing. They will describe in detail the current structure of beneficiary cost-sharing and the incentives that have arisen from the benefit design. In addition, there will be a focus on the structure and policy implications of Medigap.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, May 23, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://waysandmeans.house.gov".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairwoman JOHNSON. The hearing will come to order.

Today will be the fifth Subcommittee hearing on modernizing the Medicare program. In earlier hearings, we examined new ideas on Medicare reform. We solicited proposals to reduce the regulatory burden on providers and beneficiaries. We examined the adequacy and the usefulness of the current definition of Medicare solvency. We brought forth new information to lay the groundwork for a prescription drug benefit, and we heard about the importance of the Medicare Plus Choice program to beneficiaries and evaluated ideas to strengthen that program.

Today, we turn to modernizing the fee-for-service Medicare Program's beneficiary cost sharing. The structure of Medicare beneficiary cost sharing in the fee-for-service program reflects the insurance practices at the inception of the Medicare Program in 1965. As such, more than 35 years later, beneficiaries are confronted with irrational and confusing cost-sharing requirements which do not reflect the current delivery of health care.

For example, the program has two different deductibles, a $792 deductible for Part A and $100 deductible for Part B. This means that when a beneficiary is hospitalized for an inpatient procedure and least likely to be sensitive to pricing issues, the beneficiary is faced with a significant deductible.

In addition, after a beneficiary has been hospitalized for 2 months, the beneficiary must then pay $198 coinsurance per day for day 61 through 90. This simply makes no sense.

At the same time, the $100 Part B deductible for outpatient procedures, which are arguably more discretionary, has never been indexed to inflation. Unlike 97 percent of private health policies, the Medicare fee-for-service program still lacks catastrophic insurance protection for those with serious health conditions. Medicare Part B has unlimited beneficiary cost sharing. Part B has different coinsurance depending on the service, none for lab or home health, 20 percent for physician services and supplies, and close to 50 percent for hospital outpatient services and mental health services.

This Committee has made progress in three consecutive Medicare bills to substantially reduce beneficiary cost sharing for outpatient hospital services, but more needs to be done. In total, due to cost-sharing obligations and Medicare's limited benefit package, nearly half of seniors health care costs are not covered by Medicare. As a result, 90 percent of beneficiaries have some type of supplemental coverage. Those with retiree coverage from their former employers generally receive generous benefits, including catastrophic protection and good prescription drug coverage. The poorest beneficiaries receive wrap-around coverage through Medicaid. Medicare's confusing and irrational cost sharing has also induced 29 percent of beneficiaries to purchase Medigap insurance.

In 1990, Congress created 10 standardized Medigap policies. Nine out of the 10 of those policies, which comprise more than 90 percent of the Medigap market, are required to cover the Part A deductible, and the most popular Medigap policy covers both deductibles. Numerous studies have demonstrated that covering the deductibles has led to markedly higher Medicare spending because beneficiaries become insensitive to costs.

In addition, only the three most expensive Medigap plans cover prescription drugs, and that coverage is limited. Yet, 8 of the 10 plans are required to cover foreign travel insurance while most beneficiaries never leave the country. Between 1998 and 2000, Medigap premiums have escalated by 15.5 percent for plans without drug coverage and 37 percent for those with drug coverage. Modernizing beneficiary cost sharing must include appropriate changes in Medigap.

A critical element of strengthening Medicare is modernizing the fee-for-service programs' byzantine cost-sharing structure. No one designing a senior's health program today would construct such a convoluted and irrational cost-sharing structure for beneficiaries. The system is a patchwork of outdated policies that fail to protect beneficiaries or taxpayers. We must learn from our experience and work to ensure a more consistent, understandable, and affordable system for the future.

Mr. Stark.

[The opening statement of Chairwoman Johnson follows:]

Opening Statement of the Hon. Nancy L. Johnson, a Representative in Congress from the State of Connecticut, and Chairwoman, Subcommittee on Health

Today will be the fifth subcommittee hearing on modernizing the Medicare program. In earlier hearings we examined new ideas on Medicare reform, we solicited proposals to reduce the regulatory burden on providers and beneficiaries, we examined the adequacy and usefulness of the current definition of Medicare solvency, we brought forth new information to lay the ground work for a prescription drug benefit, and we heard about the importance of the Medicare+Choice program to beneficiaries and evaluated ideas to strengthen that program. Today, we turn to modernizing the fee-for-service program's beneficiary cost-sharing.

The structure of Medicare beneficiary cost sharing in the fee-for-service program reflects the insurance practices at the inception of the Medicare program in 1965. As such, more than 35 years later, beneficiaries are confronted with irrational and confusing cost-sharing which does not reflect the current delivery of health care.

For example, the program has two different deductibles—a $792 deductible for Part A and a $100 deductible for Part B. This means that when a beneficiary is hospitalized for an in-patient procedure and least likely to be sensitive to pricing issues, the beneficiary is faced with a significant deductible. In addition, after a beneficiary has been hospitalized for *two months*, the beneficiary must then pay $198 coinsurance per day for days 61 through 90. This simply makes no sense. At the same time, the $100 Part B deductible for out-patient procedures, which are arguably more discretionary, has never been indexed to inflation.

Unlike 97 percent of private health policies, the Medicare fee-for-service program still lacks catastrophic insurance protection for those with serious health conditions. Medicare Part B has unlimited beneficiary cost-sharing. Part B has different coinsurance depending on the service—none for lab or home health, 20 percent for physician services and supplies, and close to 50 percent for hospital outpatient services. This Committee has made progress in three consecutive Medicare bills to substantially reduce beneficiary cost-sharing for outpatient hospital services. But more needs to be done.

In total, due to cost-sharing obligations and Medicare's limited benefit package, nearly half of seniors' health care costs are not covered by Medicare. As a result, 90 percent of beneficiaries have some type of supplemental coverage. Those with retiree coverage from their former employers generally receive generous benefits, in-

cluding catastrophic protection and good prescription drug coverage. The poorest beneficiaries receive wrap-around coverage through Medicaid.

Medicare's confusing and irrational cost-sharing has also induced 29 percent of beneficiaries to purchase Medigap insurance. In 1990, Congress created 10 standardized Medigap policies. Nine out of 10 of those policies, which comprise more than 90 percent of the Medigap market, are required to cover the Part A deductible, and the most popular Medigap policy covers both deductibles. Numerous studies have demonstrated that covering the deductibles has led to markedly higher Medicare spending because beneficiaries become insensitive to costs. In addition, only the three most expensive Medigap plans cover prescription drugs, and that coverage is limited. Yet, eight of the 10 plans are required to cover foreign travel insurance, while most beneficiaries never leave the country. Between 1998 and 2000 Medigap premiums have escalated by 15.5 percent for plans without drug coverage and 37.2 percent for those with drug coverage. Modernizing beneficiary cost-sharing must include appropriate changes to Medigap.

A critical element of strengthening Medicare is modernizing the fee-for-service program's byzantine cost-sharing structure. No one designing a seniors' health program today would construct such a convoluted and irrational cost-sharing structure for beneficiaries. The system is a patchwork of outdated policies that fail to protect beneficiaries or taxpayers. We must learn for our experience and work to ensure a more consistent and understandable system for the future.

Mr. STARK. Thank you, Madam Chair.

I agree that Medicare cost sharing can benefit from a fresh look. The fact is that Medicare currently covers only about half of the beneficiary health costs, and the beneficiaries spend a disproportionate share of their income on health expenses.

Now, much of the gap is due to the lack of coverage of prescription drugs, but it is also clear that the current cost-sharing arrangement continues to force too many beneficiaries to pay too much.

We have made some modest progress to correct the coinsurance quirk that forces beneficiaries to pay far more than we intended for hospital outpatient services, but we have got a long way to go on that one. Beneficiaries do shoulder an unfair percentage of the cost for mental health services, and we have not corrected that.

I do not oppose efforts to develop or examine options in this area, but I think we must keep foremost in our mind the effects that these changes have on all Medicare beneficiaries.

For example, there are good reasons to slower the hospital deductible, but that is often considered in the context of raising the Part B deductible. Given only that 90 percent of the beneficiaries use Part B and only about less than 20 percent use the hospital benefit, we could end up reducing expenses for a few, the 20 percent that use hospitals, and then kick all the Part B costs up, and I am not sure if that is what we want to do.

While cost sharing can increase the cost awareness of beneficiaries, I see it as a sickness tax, and I have never been convinced that beyond the nuisance value of a minimal $5, $10 copay that people will overutilize medical care.

I think, mostly, we do not like going. We like doctors. Some of us are married to them. Some of us have them as colleagues.

Chairwoman JOHNSON. Some of us lucky folks are married to them.

Mr. STARK. Professionally, we do not like to visit them so much.

I have often said if I arranged with the George Washington Hospital for each one of these Subcommittee Members this afternoon to go over to George Washington Hospital and for $10, you could have a Pap smear or a proctoscopic examination, I do not think any of you would go. This is not the kind of thing that we want to do on a nice, sunny afternoon, and I do not think the Medicare beneficiaries are much different. I do not think they are out there saying, "Gosh, I do not have anything else to do. There is no ball game. There is nothing on television. I think I will go and have an examination."

Yes, I can see that there are some hypochondriac types that abuse it, but you have got to make the case to me that we will not prevent people from getting needed medical care if we raise that barrier too high.

I think that it is tempting to look at CBO's (Congressional Budget Office) projected savings from various options in this area, but the dollars come from increasing or changing beneficiary cost-sharing responsibilities that might have unintended consequences. As I say, we assume that utilization is bad, and maybe it is not.

I find it hard to believe that Medicare beneficiaries, as I said, go out of their way to just get extra cost. That may not be true of the providers or their advisors, but it certainly, I think, is true to the beneficiaries.

Benefit packages under the OBRA '90 rules could be tweaked, but I would say we should be careful not to upset a precarious market, unless you choose to eliminate Medigap. Given the strong desire of beneficiaries to purchase this insurance, my personal belief is that that would be politically unwise or, if you wanted to replace it with a HCFA-sponsored (Health Care Financing Administration) Medigap, I think politically unsellable at this time.

So I am just saying right now Medigap is the best we have got, and unless we are ready to step up to the plate and think about making it part of the Federal program, we should be very careful that we do not destroy the private providers who are in the business.

I agree that regardless of what we do with first-dollar coverage, Medigap needs improvements, and we have got beneficiaries who missed the open enrollment and they are locked out forever. We have got a problem with Medicare Plus Choice cancels. They are limited in their options to go back into Medigap. None of them have drug coverage. Maybe that will change if we have a drug benefit.

Disabled younger beneficiaries cannot get into the initial open enrollment until they are 65. I think we should look at that.

Why? I guess the insurance industry basically does not want to insure these folks, and I think we have to keep in mind their aversion to risk when we consider changes that we would ask the private insurance industry to take up.

So, while I am anxious to review what we are doing and improve it, I hope we can be cautious because we could perhaps do more harm. It is a program that is tenuous. We see people dropping out of the Medigap. I mean we see insurers dropping out of the Medigap market every year. We see it becoming more expensive, and I hope this hearing will lead us toward some of the answers

that we might do to improve the Medicare Program for all of the beneficiaries.

Thank you very much.

[The opening statements of Mr. Stark and Mr. Ramstad follow:]

Opening Statement of the Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Thank you, Madam Chairwoman, for holding this hearing. This is an impressive, balanced panel, and I look forward to the discussion.

Medicare cost-sharing could benefit from a fresh look. Medicare currently covers only approximately half of beneficiary health costs, and beneficiaries spend a disproportionate share of their income on health expenses. While much of the gap is due to the lack of coverage under Medicare for prescription drugs and other important items or services, it is also clear that the current cost-sharing arrangement continues to force too many beneficiaries to pay too much.

We have made modest progress in our effort to correct the co-insurance quirk that forces beneficiaries to pay far more than we intended for hospital outpatient services. But we have a long way to go. Beneficiaries also shoulder an unfair percentage of the cost for mental health services.

For these and other reasons, it may initially seem attractive to rearrange cost-sharing obligations. I am not averse to developing or examining options in this area, but we must keep in mind the effects of these changes on all Medicare beneficiaries. For example, there are good reasons to lower the hospital deductible, but that is often considered in the context of raising the Part B deductible. However, it is important to remember that 90 percent of beneficiaries use Part B services, while only approximately 18 percent use the inpatient hospital benefit. Any policy that lowers the hospital deductible while raising the Part B deductible reduces expenses for a few at the expense of many. While cost-sharing can be used as a tool to heighten "cost consciousness" of beneficiaries, it can also be used as a sickness tax on those who need health services the most.

I am sure that some of today's discussion will center around the so-called "first dollar coverage" under Medigap and its effect on Medicare spending. Some people think that we should prohibit Medigap and other insurance from providing coverage that essentially insulates beneficiaries from Medicare's patchwork quilt of co-insurance and co-payment obligations. I know it is intriguing to look at the options book produced by CBO and see the potential for enormous savings in some proposals, but I think a few words of caution are in order before anyone heads down that particular road.

Too often, it is *assumed* that utilization is bad. While we certainly want to curtail unnecessary utilization, cost-sharing is a blunt tool with which to accomplish that goal. Too often, it results in decreased use of both necessary and unnecessary services. Certainly, steps can be taken to minimize or direct the effects of cost-sharing, but we must keep in mind that cost-sharing requirements in a vulnerable lower-income population may result in adverse health effects. With very few exceptions, I find it hard to believe that Medicare beneficiaries seek unnecessary services. Most people are reluctant, not eager, to go to the doctor or be subject to procedures. Also, except for showing up at a doctor's office, most of us are unable to direct our care, and cost-sharing has little impact on our choices, except to discourage compliance with treatment regimens. After all, we can't order our own tests or procedures or prescribe other treatments.

In addition, the OBRA 1990 Medigap standardization legislation was desperately needed to address rampant abuses in the Medigap market. And it has largely served its purpose. Among other problems, there were reports of beneficiaries having dozens of policies, thanks to unscrupulous sales agents who preyed on unsuspecting senior citizens. Not so anymore. I admit that the benefit packages may be in need of some tweaking, but I remind my colleagues that they were designed through painful, lengthy negotiated rule-making process that involved all relevant parties. In addition, as we will hear from GAO, one-third of current Medigap policies have been in force since before 1992 and have non-standardized benefits. If Congress decides to dramatically change the benefit packages, care must be taken to avoid further segmenting the market and risk pools. Unless, of course, Congress wishes to force beneficiaries to give up the Medigap insurance they currently have. However, given the strong desire of beneficiaries to purchase this insurance, my personal belief is that it would be politically unwise to force change. On the other hand, if it is clearly a better deal, many may well be willing to voluntarily leave their current policies.

We might also consider creating a HCFA-sponsored Medigap option to compete with the private insurers. After all, given that Medigap's administrative costs and insurer profits total more than 20 percent of the premium, a HCFA option could offer equivalent coverage at a much lower price.

Finally, I would be remiss if I didn't advocate for some long-overdue Medigap improvements—regardless of what happens with respect to first-dollar coverage. Medicare beneficiaries essentially get one chance at purchasing Medigap when they first turn 65 and enroll in Part B. If they fail to take advantage of the one-time open enrollment period at that time, they may find themselves forever locked out of supplemental coverage. In addition, there are virtually no federal restrictions on underwriting or rating practices. That means that even if an insurer agrees to offer you coverage, they can charge you whatever they want. Or they can entice you in at age 65 with an attractive premium, while raising it as your age and needs increase. That's one reason why enrollment in the Medigap drug packages is so low. Their value is questionable, and most beneficiaries with any indication of need are priced out of the plans. When Congress finally acted to allow beneficiaries whose circumstances change beyond their control (e.g., M+C plan cancels, employer benefits drop, etc.) to get another chance at enrollment, we limited their ability to enroll or re-enroll to just four options—none with drug coverage. Disabled younger beneficiaries are still waiting to get an initial open enrollment period upon first becoming eligible for Medicare. Right now, they have to wait until they are 65 to be guaranteed an opportunity to purchase Medigap. Why are these things so? Because the insurance industry doesn't want to insure these folks. Keep this aversion to risk in mind as we consider other changes to Medicare that would increase the role of the private insurance industry.

Caution is the watchword as we work in this important area. There is an opportunity for improvement, but also for destruction. I look forward to today's testimony and discussion.

Opening Statement of the Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Madam Chairwoman, thank you for calling this important hearing today to continue exploring Medicare reform.

I strongly believe that Medicare needs comprehensive reform. We cannot focus on tinkering around the edges, and we must not take the easy road of simply adding a prescription drug benefit to an already overburdened program.

I am particularly concerned about the costs that Medicare beneficiaries must pay when they get sick and the plans they must purchase to cover their needs because of Medicare's copays and lack of catastrophic coverage.

For example, the program has a $792 deductible for Part A when the patient is least sensitive to price; after 60 days in the hospital, a beneficiary must pay $198 coinsurance *per day* for days 61 through 90. In Part B, a beneficiary must pay a $100 which has never been adjusted for inflation.

This problem is exacerbated by the fact that Medicare lacks catastrophic protection. This compares with 97% of private health policies which have this protection.

In total, Medicare's limited benefits package, high copays and complete absence of catastrophic coverage means that nearly half of our seniors' health care costs are not covered by Medicare.

This means that Medicare seniors must bear the cost themselves. In fact, 90% of beneficiaries have some type of supplemental coverage which ranges from quite good to very limited.

In my view, Madam Chairwoman, this is just another example of why we must bring the Medicare program into the 21st century, and do it this year. I believe that together, in a bipartisan way, we can design an effective and efficient way to comprehensively improve the system and preserve it for tomorrow's seniors.

Madam Chairwoman, thanks again for your leadership. I look forward to learning more from today's witnesses on how we can best address this critical issue.

Chairwoman JOHNSON. Thank you, Mr. Stark.

The panel that we are going to hear from today will start with Jennifer O'Sullivan who is the specialist in Social Legislation, Do-

mestic Social Policy Division of the Congressional Research Service; Dr. William Scanlon who is the director of Health Care Issues at the United States General Accounting Office; Dr. Christopher Hogan, president of Direct Research of Vienna, Virginia; and Dr. Karen Davis, president of The Commonwealth Fund of New York, New York.

Ms. O'Sullivan, if you would start, please.

STATEMENT OF JENNIFER O'SULLIVAN, SPECIALIST IN SOCIAL LEGISLATION, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS

Ms. O'SULLIVAN. Thank you, Madam Chairman and Members of the Subcommittee. My name is Jennifer O'Sullivan.

Today, you have asked me to outline Medicare's cost-sharing structure, specifically what out-of-pocket expenses beneficiaries are liable for when they use covered services. My testimony will highlight three points: first, Medicare's cost-sharing requirements are complex; second, the cost-sharing requirements differ in significant ways from those applicable in the private market; and, third, Medicare's requirements remain relatively unchanged since 1966.

There are very significant differences between the cost-sharing requirements under Medicare Part A and Medicare Part B. Medicare Part A uses a spell-of-illness concept. A spell of illness, also known as a benefit period, starts when a beneficiary enters a hospital and ends when he or she has not been in a hospital or skilled nursing facility for 60 days. In each benefit period, the beneficiary pays a $792 deductible for hospital stays up to 60 days. Longer stays are subject to coinsurance charges. Days 60 to 90 are subject to a daily charge of $198, and persons in the hospital over 90 days may draw on 60 lifetime reserve days subject to a daily coinsurance charge of $396. There is no coverage after 150 days.

The spell-of-illness concept gets even more complex when you consider that an individual can have more than one benefit period in a calendar year and, therefore, have to pay more than one deductible in a calendar year.

A person requiring post-hospital skilled nursing facility services may get up to 100 days of care in a benefit period. There is a daily coinsurance charge of $99 for days 21 to 100.

In general, cost sharing under Medicare Part B is somewhat simpler. In each calendar year, beneficiaries must first meet the $100 Part B deductible. Beneficiaries then generally pay 20 percent in coinsurance. However, certain Part B services such as home health services, lab services, and some preventive services are exempt from either the deductible and/or coinsurance requirements. On the other hand, mental health services are subject to 50-percent cost sharing. Beneficiaries using hospital outpatient services pay a fixed amount which varies by the service category, and this amount is often considerably above 20 percent of the approved Medicare payment amount.

There are significant differences between Medicare's cost-sharing structure and that available to the under-age-65 population under employer-based plans. Perhaps the most significant difference is that private plans typically have an annual limit on out-of-pocket

expenses, sometimes referred to as a catastrophic cap. In contrast, Medicare has on upper limit on cost-sharing charges.

Another key feature of the private insurance market is that over 95 percent of the under-65 population is enrolled in a managed-care arrangement compared to only about 15 percent of the Medicare population. These managed-care arrangements typically have simpler cost-sharing structures. Many of the under-65 population are enrolled in preferred provider plans. Individuals in these plans have lower cost sharing when they use in-network providers and somewhat higher cost sharing when they use out-of-network providers. These preferred provider arrangements are not available to the Medicare fee-for-service population.

Several other observations can be made about Medicare's cost sharing. While the dollar amounts have changed, the structure is virtually unchanged from that which was in effect when the program started in 1966. The Congress did enact legislation in 1988, the Medicare Catastrophic Act, which would have significantly modified the requirements, and one of the key features of that legislation was an annual out-of-pocket limit on Part B cost-sharing. However, as you know, Congress repealed that legislation in the following year.

I should note that the preceding discussion has focused on beneficiary liability in connection with their use of Medicare services. Unlike the under-age-65 population, most beneficiaries have a second source of health insurance coverage. This supplementary coverage typically covers some or all of Medicare's cost-sharing charges. As a result, beneficiaries may not actually incur out-of-pocket costs at the time they use covered services.

This discussion only focuses on cost sharing for Medicare-covered services. It does not address expenses beneficiaries may have for non-covered services. As you know, Medicare does not cover certain items such as hearing aids and dentures. It also provides very limited coverage for some other services such as outpatient prescription drugs and long-term care. As a result, Medicare only covers about half of the beneficiary's total health care bill.

Thank you.

[The prepared statement of Ms. O'Sullivan follows:]

Statement of Jennifer O'Sullivan, Specialist in Social Legislation, Congressional Research Service, Library of Congress

Madam Chairman and Members of the Subcommittee. My name is Jennifer O'Sullivan. I am a Specialist in Social Legislation at the Congressional Research Service. Today you have asked me to outline Medicare's cost-sharing structure-specifically what out-of-pocket expenses beneficiaries are liable for when they use covered services. I will briefly summarize Medicare's requirements under the traditional fee-for-service program; more details are provided in the table included as part of my written testimony. My testimony will highlight three points:

- First, Medicare's cost-sharing requirements are complex;
- Second, the cost-sharing requirements differ in significant ways from those applicable in the private market;
- Third, Medicare's requirements have remained relatively unchanged from 1966.

There are significant differences between the cost sharing requirements for Medicare Part A and Medicare Part B. Part A uses the "spell of illness" concept. A spell of illness, also known as a "benefit period" starts when a person enters a hospital and ends when he or she has not been in a hospital or skilled nursing facility for 60 days. In each benefit period, the beneficiary pays a $792 (in 2001) deductible for hospital stays of 1—60 days. Hospital stays beyond 60 days are subject to coinsur-

ance charges. Days 60—90 are subject to a daily charge of $198 (in 2001). Persons in the hospital over 90 days may draw on 60 lifetime reserve days subject to a daily coinsurance charge of $396 (in 2001). Hospital stays in excess of 150 days in a benefit period are not covered.

The spell of illness concept gets even more complex when you consider that an individual can have more than one benefit period in a year and therefore have to pay more than one deductible in a year. Potentially, an individual could even have to pay coinsurance charges for more than one inpatient stay.

A person requiring post-hospital skilled nursing facility (SNF) services may get up to 100 days of care in a benefit period. There is a daily coinsurance charge for days 21—100 ($99 in 2001). There is no cost sharing for home health services and nominal cost-sharing for hospice care.

In general, cost-sharing under Medicare Part B is somewhat simpler. In each calendar year, beneficiaries must first meet the $100 Part B deductible before the program will begin making payments. Beneficiaries are then subject to coinsurance which equals 20% of Medicare's approved amount. Certain Part B services, such as home health care and some preventive services, are exempt from the deductible and/or coinsurance requirements. On the other hand, mental health services are subject to 50% cost sharing. Beneficiaries using hospital outpatient services pay a fixed amount which varies by service category; this fixed amount is often substantially more than 20% of the approved payment for the service under the new outpatient prospective payment system.

There are a number of differences between Medicare's cost-sharing structure and that available to the under-65 population under private employer-based plans. Perhaps the most significant difference is that private plans typically have an annual limit on out-of-pocket expenses—sometimes referred to as a catastrophic cap. In contrast, Medicare has no upper limit on cost-sharing charges.

Another key feature of the private insurance market is that over 90% of the under 65 population is enrolled in a managed care arrangement compared to only 15% of the Medicare population. These managed care arrangements typically have simpler cost-sharing structures. Many of the under-65 population are enrolled in preferred provider plans. Individuals in these plans have lower cost-sharing charges when they use specific network providers and higher cost-sharing when they use out-of-network providers. These preferred provider arrangements are not available to the fee-for-service Medicare population.

Several other observations can be made about Medicare's cost-sharing. While the dollar amounts have changed, the structure is virtually unchanged from that in effect when the program went into effect in 1966. For example, the concept of a spell of illness was part of the original legislation. The Congress did enact legislation in 1988, the Medicare Catastrophic Coverage Act, which would have significantly modified current requirements. One of the key features of that legislation was the addition of an annual limit on Part B out-of-pocket spending. However, as you know, this legislation was repealed the following year.

Medicare Part B cost-sharing applies to a broader range of services than when the program first went into effect. This is true for two reasons. Medicare Part B now covers a number of additional services. It also pays directly for some practitioner services previously covered indirectly under other service categories.

I should note that the preceding discussion has focused on beneficiary liability in connection with their use of Medicare services. Unlike the under-age 65 population, most Medicare beneficiaries have a second source of health insurance coverage. This supplementary coverage typically covers some or all of Medicare's cost sharing charges, thus further complicating the picture. As a result of supplementary insurance, beneficiaries may not actually incur out-of-pocket costs at the time they use covered services.

I should also note that this discussion only focuses on cost-sharing charges for Medicare-covered services. It does not address expenses beneficiaries may have for non-covered services. As you know Medicare does not cover certain items such as hearing aids and dentures. It also provides very limited coverage for some other services such as outpatient prescription drugs and long-term care. As a result, Medicare covers only about half of a beneficiary's health care bill.

COMPARISON OF MEDICARE COST-SHARING AND BENEFITS—1966 AND 2001

	1966	2001
Part A		
Inpatient Hospital Services.	Coverage up to 90 days in each spell of illness:. —Days 1–60: deductible ($40 in 1966). —Days 61–90: daily coinsurance equal to ¼ of deductible ($10 in 1966). No lifetime reserve days ..... [Deductible based on average per diem rate for inpatient services.].	Same except: —2001 deductible is $792 and daily coinsurance is $198. 60 lifetime reserve days: daily coinsurance equal to ½ of hospital deductible ($396 in 2001). [Deductible set at $520 in 1987. It is updated each year based on the applicable percentage increase used for Medicare's prospective payment rates, adjusted to reflect changes in real case mix.]
Inpatient psychiatric hospital services.	Maximum 190 days per lifetime (covered as part of inpatient hospital benefit).	Same.
Skilled Nursing Facility (SNF) Services.	Maximum of 100 post-hospital days per spell of illness:. —Days 1–20: No coinsurance ..... —Days 21–100: daily coinsurance equal to ⅛ hospital deductible ($5 in 1967—first year benefit in effect).	Same except daily coinsurance is $99 in 2001.
Hospice Services	Not covered	Covered for terminally ill beneficiaries with life expectancy of 6 months or less. Limited cost-sharing for drugs and respite care.
Blood deductible	Covered all but cost of first three pints in spell of illness.	Same, except waived if blood replaced. [Any deductible required under Part A or B offsets requirements under other Part.]
Part B		
In General		
Part B Premium	Set in law to cover 50% of program costs ($3.00/month 1966).	Set in law to cover 25% of program costs ($50 a month in 2001).
Deductible	$50	$100.
Blood deductible	No provision	Medicare covers 80% of approved amount after beneficiary pays (or replaces) first 3 pints per year. [Any deductible required under Part A or B offsets requirements under other Part.]
Services		
Physicians	Services provided by doctors of medicine and osteopathy, and, under limited circumstances, dentists. Covered for 80% of reasonable charges; beneficiary pays 20%.	Services provided by doctors of medicine and osteopathy, and, under limited circumstances, dentists. Also specific services provided by doctors of optometry, podiatry, and chiropractic. Covered for 80% of fee schedule; beneficiary pays 20%.

COMPARISON OF MEDICARE COST-SHARING AND BENEFITS—1966 AND 2001—Continued

	1966	2001
Non-physician Practitioners.	Not paid directly	Services provided by physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, psychologists, certified registered nurse anesthetists, and certified nurse midwives. Covered for 80% of approved amount; beneficiary pays 20%.
Physical Therapists, and Occupational Therapists.	Not paid directly	Services provided by therapists in independent practice. Covered for 80% of approved amount; beneficiary pays 20%.
Durable Medical Equipment.	Rentals covered for 80% of approved amount; beneficiary pays 20%.	Rental or purchase covered for 80% of approved fee schedule amount; beneficiary pays 20%.
Prosthetic devices ...	Covered for 80% of approved amount; beneficiary pays 20%.	Same, except coverage for orthotics added. Covered for 80% of approved fee schedule amount; beneficiary pays 20%.
Outpatient Mental Health Treatment.	Limited to the lesser of $250 or 50% of approved amount; beneficiary pays remainder.	Limited to 50% of fee schedule amount; beneficiary pays 50%.
Partial Hospitalization Services for Mental Illness.	Not covered	Covered for 80% of approved amount; beneficiary pays 20%.
Outpatient Hospital Services (excludes services which are paid under another service category).	Covered for 80% of approved amount; beneficiary liable for 20% of charges. Diagnostic services covered for 80% of approved amount under Part A after beneficiary met deductible equal to ½ of Part A deductible ($20 in 1966).	Covered under Part B. Beneficiary pays fixed amount which varies by service category; Medicare pays the remainder.
Clinical Laboratory Services.	Covered for 80% of approved amount; beneficiary pays 20%.	Covered for 100% of fee schedule amount. No cost-sharing.
Comprehensive Outpatient Rehabilitation Facility (CORF) Services.	No provision	Covered for 80% of approved amount; beneficiary pays 20%.
Ambulatory Surgical Center (ASC) Services.	No provision	Covered for 80% of approved amount; beneficiary pays 20%.
Ambulance Services	Covered for 80% of approved amount; beneficiary pays 20%.	Same.
Benefit Category		
Outpatient Prescription Drugs.	Coverage limited to drugs and biologicals which are not self-administered and are incident to physicians services. Covered for 80% of approved amounts; beneficiary pays 20%.	Same, except coverage also provided for: —immunosuppressive drugs following a covered organ transplant; —erythropoietin for treatment of anemia for persons with chronic renal failure; —oral anti-cancer drugs comparable to chemotherapy drugs which would be covered if they were not self-administered; and —hemophilia clotting factors.

COMPARISON OF MEDICARE COST-SHARING AND BENEFITS—1966 AND 2001—Continued

	1966	2001
Immunizations	Not covered	Vaccine coverage for influenza, pneumococcal pneumonia, and Hepatitis B. No cost-sharing for influenza and pneumococcal pneumonia.
Screening mammography.	Not covered	Pays up to limit ($69.23 in 2001) for exam. Beginning 1/1/2002 paid under physician fee schedule. Beneficiary pays 20%. Deductible waived.
Screening pap smear.	Not covered	Covered, generally at 3-year intervals (2-year intervals beginning 7/1/2001), for 100% of approved amount.
Colorectal screening	Not covered	Covered for 80% of approved amounts according to periodicity schedule; beneficiary pays 20%. (No coinsurance for fecal occult blood test. Coinsurance is 25% if service performed in ambulatory surgical center or hospital outpatient department.)
Diabetes self-management training services.	Not covered	Covered for 80% of approved amounts; beneficiary pays 20%.
Bone Mass measurement.	Not covered	Covered for 80% of approved amounts for high risk persons; beneficiary pays 20%.
Prostate screening exam.	Not covered	Covered for 80% of approved amounts for digital rectal exam; beneficiary pays 20%. No cost-sharing for prostate specific antigen test.
Parts A and B		
Home Health Services.	Part A: Maximum of 100 post-hospital visits. Covered for 100% of approved amount. Part B: Maximum of 100 visits per year (with no prior hospitalization requirement)—covered for 80% of approved amount.	Covered for those who need it on an intermittent basis without visit limitations, coinsurance, or deductibles. Over 1998–2003 period, home health visits that are not part of the first 100 visits following a hospital or SNF stay are being transferred from Part A to Part B.
End Stage Renal Disease (ESRD).	Not covered	Services for ESRD patients are covered under Part A and B, as appropriate. For example, transplants are covered as Part A inpatient hospital services and Part B physicians services. Dialysis is generally covered under Part B.

Chairwoman JOHNSON. Thank you.
Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Dr. SCANLON. Thank you very much, Madam Chairwoman and Mr. Stark and Subcommittee members.

I am very pleased to be here today as you continue to consider the need to modernize and strengthen Medicare and particularly as you look into the area of beneficiary cost sharing.

Medicare provides valuable and extensive coverage, but it has not kept pace with the changing health care needs and private insurance practices of today. Essentially, there are two issues with cost sharing for Medicare beneficiaries. First, Medicare does not provide genuine insurance; that is, protection from catastrophe. Gaps in Medicare's benefit package, such as the lack of prescription drug coverage as well as required copayments for covered services, can contribute to substantial financial burdens for beneficiaries.

Second, how that deficiency has been addressed, namely through most beneficiaries having some form of supplemental insurance, creates additional issues. Of particular concern are Medigap policies which can be expensive, not offer comprehensive protection, and increase use of potentially discretionary services.

I would like to summarize some of the information on those two points from my written statement before you today. Health insurers commonly include cost-sharing provisions in their policies to make beneficiaries aware of cost. The goal is to encourage prudent use of services that may be discretionary and at the same time avoid creating financial barriers to necessary care.

Medicare cost-sharing rules diverge from these practices in important ways. While Medicare's cost-sharing requirements can be substantial, they are not designed well to discourage unnecessary use of services. Given the example that you gave, Madam Chairman, Medicare imposes a relatively high deductible for hospital stays and no coverage for extremely long stays, which are rarely optional. In contrast, it requires no cost sharing for home health care where utilization has been seen to vary widely raising concerns about the appropriateness of use.

Meanwhile, the lack of a cost-sharing limit on Medicare-covered services can leave beneficiaries with extensive health care needs liable for very large expenses. Employer-sponsored plans, as Ms. O'Sullivan indicated, typically limit out-of-pocket costs to less than $2,000 per year, but many Medicare beneficiaries pay much more than that. In 1997, more than 3.4 million were liable for more than $2,000 on covered services, and approximately 750,000 were liable for more than $5,000.

In addition, uncovered services like prescription drugs add to Medicare's beneficiaries' financial risk. On average, beneficiaries were estimated to spend about $3,100, or 22 percent of their incomes, on total out-of-pocket expenses, and this is excluding long-term care in the year 2000. Those in poor health without Medicaid or supplemental coverage spent 44 percent of their incomes.

Most beneficiaries do have supplemental coverage, however. Some get it from former employers, Medicare Plus Choice plans, or State Medicaid programs. However, Medigap is the only supplemental coverage available to all elderly Medicare beneficiaries, and more than one-fourth have purchased a Medigap policy.

Medigap itself, though, is problematic. These policies can be expensive. Annual premiums average more than $1,300. Premiums for plans offering drug coverage are about $400 more and are rising rapidly.

In the last year alone, these premiums increased 17 to 34 percent for the three types of plan that offer drug coverage. Premiums vary widely also across geographic areas and insurers. For example, in Massachusetts, premiums average 45 percent more than the national average.

Many policies have premiums that rise with the purchaser's age. In addition, individuals in poor health can find policies difficult to obtain or expensive as many insurers screen purchasers' for poor health status. Guaranteed access is only assured for that short period that generally follows initial enrollment into Part B.

Despite their high costs, Medigap policies do not fully protect beneficiaries. Medigap prescription drug coverage, in particular, can be inadequate because policies have relatively low caps on how much is covered and require beneficiaries to pay most of the cost of their drugs.

In addition, there is concern about Medigap's so-called first dollar coverage that eliminates beneficiary liability for deductibles, copayments, and coinsurance. Employer-sponsored supplemental policies in Medicare Plus Choice plans typically reduce such liabilities, but do not offer first dollar coverage. First dollar coverage undermines the objective of Medicare's cost-sharing requirements to promote prudent use of services. As a result, some services may be overused, ultimately increasing cost for both the beneficiary and the program.

I would end by saying as you continue to consider how to modernize and to reform Medicare, focusing on beneficiaries' financial liabilities and risks is very important. Reconsideration of coverage in cost-sharing policies, while difficult, both within the Medicare program and with any supplemental options that may be available could improve coverage for beneficiaries and the financial health of the program.

Thank you very much, Madam Chairwoman. I would be happy to answer any questions you or members of the Subcommittee may have.

[The prepared statement of Dr. Scanlon follows:]

Statement of William J. Scanlon, Ph.D., Director, Health Care Issues, U.S. General Accounting Office

I am pleased to be here today as you consider the need to modernize and strengthen the Medicare program and review the role of supplemental "Medigap" policies that many seniors buy to help improve their Medicare coverage. Medicare provides valuable and extensive coverage for beneficiaries' health care needs. Nevertheless, recent discussions have underscored the significant gaps that leave some beneficiaries vulnerable to sizeable financial burdens from out-of-pocket costs. Most beneficiaries have additional supplemental coverage that helps to fill Medicare's coverage gaps and pay some out-of-pocket expenses. Privately purchased Medigap is an important source of this supplemental coverage because it is widely available to beneficiaries. The other sources—employer-sponsored policies, Medicare+Choice plans, and Medicaid programs—are not available to all beneficiaries. However, concerns exist that supplemental coverage can be expensive and may undermine the legitimate role of cost sharing in a health insurance plan—to encourage cost-effective use of services.

To assist the Subcommittee as it considers proposals to improve coverage for beneficiaries and the financial health of the Medicare program, my remarks today focus on the design of Medicare's benefit package and the role of private supplemental coverage. Specifically, I will discuss (1) beneficiaries' potential financial liability under Medicare's current benefit structure and cost-sharing requirements, (2) the cost of Medigap policies and the extent to which they provide additional coverage, and (3) concerns that Medigap's so-called "first dollar" coverage undermines the cost control incentives of Medicare's cost-sharing requirements. My comments are based on our prior and ongoing work [1] on Medicare and Medigap as well as other published research.

In summary, Medicare's benefits package and cost-sharing requirements leave beneficiaries liable for high out-of-pocket costs. As currently structured, Medicare provides no limit on out-of-pocket spending and no coverage for most outpatient prescription drugs—a component of medical care that is of growing importance in treatment and rapidly increasing in cost. At the same time, Medicare's cost-sharing requirements are poorly targeted and fail to promote prudent use of services.

Medigap policies that many Medicare beneficiaries purchase help to fill in some of Medicare's gaps but are themselves problematic. Premiums paid for Medigap policies averaged $1,300 in 1999, with 20 percent going to administrative costs. While these policies pay for some or all Medicare cost-sharing requirements, they do not fully protect beneficiaries from potentially significant out-of-pocket costs. In particular, some Medigap policies offer prescription drug coverage, however, this coverage can be inadequate because beneficiaries still pay most of the cost and the maximum Medigap benefit is capped. In addition, Medigap first-dollar coverage eliminates the effect Medicare's cost-sharing requirements could have to promote prudent use of services. The danger is that some services may be overused—ultimately increasing costs for beneficiaries and the Medicare program.

BACKGROUND

Individuals who are eligible for Medicare automatically receive Hospital Insurance (HI), known as Part A, which helps pay for inpatient hospital, skilled nursing facility, hospice, and certain home health care services. Beneficiaries pay no premium for this coverage but are liable for required deductibles, coinsurance, and copayment amounts. (See table 1.) Medicare eligible beneficiaries may elect to purchase Supplementary Medical Insurance (SMI), known as Part B, which helps pay for selected physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for Part B coverage, currently $50 per month.[2] Beneficiaries are also responsible for Part B deductibles, coinsurance, and copayments.

Table 1: Medicare Coverage and Beneficiary Cost-Sharing for 2001

	Beneficiary copayments, coinsurance, and deductibles:
Part A Coverage:	
Inpatient hospital	$792 deductible per admission.[a] $198 copayment per day for days 61–90. $396 copayment per day for days 91–150. All costs beyond 150 days.
Skilled nursing facility	No cost sharing for first 20 days. $99 copayment or less for days 21–100. All costs beyond 100 days.
Home health	No cost sharing. 20 percent coinsurance for durable medical equipment.
Hospice	$5 copayment for outpatient drugs. 5 percent coinsurance for inpatient respite care.
Blood	Cost of first 3 pints.
Part B Coverage:[b]	
Physician and medical	$100 deductible each year. 20 percent coinsurance for most services. 50 percent coinsurance for mental health services.
Clinical laboratory	No cost sharing.
Home health	No cost sharing. 20 percent coinsurance for durable medical equipment.

[1] The Consolidated Appropriations Act of 2000 mandated that we report to the Congress by July 2001 on various aspects of Medigap coverage.

[2] The premium amount is adjusted each year so that expected premium revenues equal 25 percent of expected Part B spending.

Table 1: Medicare Coverage and Beneficiary Cost-Sharing for 2001—Continued

	Beneficiary copayments, coinsurance, and deductibles:
Outpatient hospital	Coinsurance varies by service and may exceed 50 percent.
Blood	Cost of first 3 pints. 20 percent coinsurance for additional pints.

[a] No deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient stay.

[b] No cost-sharing is required for certain preventive services—including specific screening tests for colon, cervical, and prostate cancer, and flu and pneumonia vaccines.

Source: *Medicare & You 2001*, Health Care Financing Administration. Most Medicare beneficiaries have some type of supplemental coverage to help pay for Medicare cost-sharing requirements as well as some benefits not covered by Medicare. They obtain this coverage either through employers, Medicare+Choice plans, state Medicaid programs, or Medigap policies sold by private insurers.

About one-third of Medicare's 39 million beneficiaries have employer-sponsored supplemental coverage. These benefits typically pay for some or all of the costs not covered by Medicare, such as coinsurance, deductibles, and prescription drugs. However, many beneficiaries do not have access to employer-sponsored coverage. A recent survey found that more than 70 percent of large employers with at least 500 employees did not offer these health benefits to Medicare-eligible retirees.[3] Small employers are even less likely to offer retiree health benefits.

Approximately 15 percent of Medicare beneficiaries enroll in Medicare+Choice plans, which include health maintenance organizations and other private insurers who are paid a set amount each month to provide all Medicare-covered services. These plans typically offer lower cost-sharing requirements and additional benefits compared to Medicare's traditional fee-for-service program, in exchange for a restricted choice of providers. However, Medicare+Choice plans are not available in all parts of the country. As of February 2001, about a third of all beneficiaries lived in counties where no Medicare+Choice plans were offered.

About 17 percent of Medicare beneficiaries receive assistance from Medicaid, the federal-state health financing program for low-income aged and disabled individuals. All Medicare beneficiaries with incomes below the federal poverty level can have their Medicare premiums and cost sharing paid for by Medicaid. Beneficiaries with incomes slightly above the poverty level may have all or part of their Medicare premium paid for by Medicaid. Also, some low-income individuals may be entitled to full Medicaid benefits (so called "dual eligibles"), which include coverage for certain services not available through Medicare, such as outpatient prescription drugs. However, the income level at which beneficiaries qualify for full Medicaid benefits varies, as determined by each state, and many Medicare beneficiaries with low incomes may not qualify.[4]

Medigap is the only supplemental coverage option available to all beneficiaries when the initially enroll in Medicare at age 65 or older. Medigap policies are offered by private insurance companies in accordance with state and federal insurance regulations. In 1999, more than 10 million individuals—more than one-fourth of all beneficiaries—were covered by Medigap policies.[5] The Omnibus Budget Reconciliation Act (OBRA) of 1990[6] required that Medigap policies be standardized and allowed a maximum of 10 different benefit packages offering varying levels of supplemental coverage to be provided. All policies sold since July 31, 1992 have offered one of the 10 standardized packages, known as plans A through J. (See table 2.) Policies sold prior to August 1992 were not required to comply with the standard benefit package requirements.

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[3] Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2000 William M. Mercer, Incorporated (New York, New York).

[4] In addition, many low-income beneficiaries who are eligible for Medicaid and other federal/state programs to provide assistance with premiums and cost-sharing requirements may not enroll, in part due to limited awareness of these programs and the administrative complexity of demonstrating eligibility. *See Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment* (GAO/HEHS–99–61, April 9, 1999). Aiming to increase awareness and enrollment in these programs, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed the Social Security Administration to identify and notify potentially eligible individuals and the Department of Health and Human Services to develop and distribute to states a simplified uniform enrollment application.

[5] The National Association of Insurance Commissioners reports that Medigap enrollment has declined from about 14 million in 1994.

[6] P. L. 101–508, Nov. 5, 1990.

Table 2: Benefits Covered by Standardized Medigap Policies

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F[a]	Plan G	Plan H	Plan I	Plan J[a]
Coverage for ..... • Part A coinsurance • 365 additional hospital days during lifetime • Part B coinsurance • Blood products	X	X	X	X	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B balance billing[b]						X	X		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
Home health care				X			X		X	X
Prescription drugs								X[c]	X[c]	X[d]
Preventive medical care					X					X

[a] Plans F and J also have a high deductible option of $1,580, under which beneficiaries also pay deductibles for prescriptions ($250 per year for Plan J) and foreign travel emergency ($250 per year for Plans F and J).

[b] Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15 percent higher than the Medicare payment rate. Plan G pays 80 percent of balance billing; Plans F, I, and J cover 100 percent of these charges.

[c] Plans H and I pay 50 percent of drug charges up to $1,250 per year and have a $250 annual deductible.

[d] Plan J pays 50 percent of drug charges up to $3,000 per year and has a $250 annual deductible.

Source: HCFA 2001 Guide to Health Insurance for People with Medicare. Note: This chart does not apply in Massachusetts, Minnesota, and Wisconsin, where alternative standards exist.

Under OBRA 1990, Medicare beneficiaries are guaranteed access to Medigap policies within 6 months of enrolling in Part B regardless of their health status. Subsequent laws have added guarantees for certain other beneficiaries. Beneficiaries who either terminated their Medigap policy to join a Medicare+Choice plan or enrolled in a Medicare+Choice plan when first becoming eligible for Medicare and then leave the plan within one year are also guaranteed access to any Medigap policy. Also, individuals whose employers eliminate retiree benefits or whose Medicare+Choice plans leave the program or stop serving their areas are guaranteed access to 4 of the 10 standardized Medigap policies (plans A, B, C, and F) but none of the policies that include prescription drug coverage.[7] Otherwise, insurers can either deny coverage or charge higher premiums to beneficiaries who are older or in poorer health.

MEDICARE COST-SHARING REQUIREMENTS AND BENEFIT DESIGN ARE OUT OF STEP WITH CURRENT PRIVATE SECTOR PRACTICES

Medicare's design has changed little since its inception 35 years ago, and in many ways has not kept pace with changing health care needs and private sector insurance practices. Medicare cost-sharing requirements are not well designed to discourage unnecessary use of services. At the same time, they can create financial barriers to care. In addition, the lack of a cost-sharing limit can leave some beneficiaries with extensive health care needs liable for very large Medicare expenses. Moreover, gaps in Medicare's benefit package can contribute to substantial financial burdens on beneficiaries who lack supplemental insurance or Medicaid coverage.

Medicare's Cost-Sharing Requirements Not Well Structured

Health insurers commonly design cost-sharing provisions—in the form of deductibles, coinsurance, and copayments—to ensure that beneficiaries are aware there is a cost associated with the provision of services and to encourage them to use services prudently. Ideally, cost sharing should encourage beneficiaries to evaluate the need for discretionary care but not discourage necessary care. Optimal cost-sharing designs would generally require coinsurance or copayments for services that may be discretionary and could potentially be overused, and would also aim to steer patients to lower cost or better treatment options. Care must be taken, however, to avoid setting cost-sharing amounts so high as to create financial barriers to necessary care.

The benefit packages of Medicare+Choice plans illustrate cost-sharing arrangements that have been designed to reinforce cost containment and treatment goals. Most Medicare+Choice plans charge a small copayment for physician visits ($10 or less) and emergency room services (less than $50). Relatively few Medicare+Choice plans charge copayments for hospital admissions. Plans that offer prescription drug benefits typically design cost-sharing provisions that encourage beneficiaries to use cheaper generic drugs or brand name drugs for which the plan has negotiated a discount.

Medicare fee-for-service cost-sharing rules diverge from these common insurance industry practices in important ways. For example, as indicated in table 1, Medicare imposes a relatively high deductible for hospital admissions, which are rarely optional. In contrast, Medicare requires no cost sharing for home health care services, even though historically high utilization growth and wide geographic disparities in the use of such services have raised concerns about the potentially discretionary nature of some services.[8] Medicare also has not increased the Part B deductible since 1991. For the last 10 years the deductible has remained constant at $100 and has thus steadily decreased as a proportion of beneficiaries' real income.

Medicare Does Not Limit Beneficiaries' Cost-Sharing Liability

Also unlike most employer-sponsored plans for active workers, Medicare does not limit beneficiaries' cost-sharing liability, which can represent a significant share of their personal resources. Premiums, deductibles, coinsurance, and copayments that beneficiaries are required to pay for services that Medicare covers equaled an estimated 23 percent of total Medicare expenditures in 2000. The average beneficiary who obtained services in 1997 had a total liability of $1,451, consisting of $925 in Medicare copayments and deductibles in addition to the $526 in annual Part B premiums required that year.

The burden of Medicare cost sharing can be much higher, however, for beneficiaries with extensive health care needs. In 1997, the most current year of avail-

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[7] These protections were added by section 4003 of the Balanced Budget Act of 1997 (P.L. 105–33, 111 Stat. 330). In addition to these federal protections, 21 states provide for additional Medigap protections.

[8] See Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available (GAO/HEHS–00–9, Apr. 2000).

able data on the distribution of these costs, slightly more than 3.4 million beneficiaries (11.4 percent of beneficiaries who obtained services) were liable for more than $2,000. Approximately 750,000 of these beneficiaries (2.5 percent) were liable for more than $5,000, and about 173,000 beneficiaries (0.6 percent) were liable for more than $10,000. In contrast, private employer-sponsored health plans typically limit maximum annual out-of-pocket costs for covered services to less than $2,000 per year for single coverage.[9]

Cost of Uncovered Services Adds to Beneficiaries' Financial Burden

Medicare does not cover some services that are commonly included in private insurers' benefit packages. The most notable omission in Medicare's benefit package is coverage for outpatient prescription drugs. This benefit is available to most active workers enrolled in employer-sponsored plans. More than 95 percent of private employer-sponsored health plans for active workers cover prescription drugs, typically providing comprehensive coverage with relatively low cost-sharing requirements.

Current estimates suggest that the combination of Medicare's cost-sharing requirements and limited benefits leaves about 45 percent of beneficiaries' health care costs uncovered. The average beneficiary in 2000 is estimated to have incurred about $3,100 in out-of-pocket expenses for health care—an amount equal to about 22 percent of the average beneficiary's income.[10]

Some beneficiaries potentially face much greater financial burdens for health care expenses. For example, elderly beneficiaries in poor health and with no Medicaid or supplemental insurance coverage are estimated to have spent 44 percent of their incomes on health care in 2000. Low-income single women over age 85 in poor health and not covered by Medicaid are estimated to have spent more than half (about 52 percent) of their incomes on health care services.[11] These percentages are expected to increase over time as Medicare premiums and costs for prescription drugs and other health care goods and services rise faster than incomes.

MEDIGAP POLICIES ADDRESS SOME MEDICARE SHORTCOMINGS BUT ARE EXPENSIVE

While more than one-fourth of beneficiaries have Medigap policies to fill Medicare coverage gaps, these policies can be expensive and provide only limited protection from catastrophic expenses. Medigap drug coverage in particular offers only limited protection because of high cost sharing and low coverage caps.

Medigap Fills Some Needs

More than 10 million Medicare beneficiaries have Medigap policies to cover some potentially high costs that Medicare does not pay, including cost-sharing requirements, extended hospitalizations, and some prescription drug expenses. By offering a choice among standardized plans, beneficiaries can match their coverage needs and financial resources with plan coverage. Medigap policies are widely available to beneficiaries including those who are not eligible for or do not have access to other insurance to supplement Medicare, such as Medicaid or employer-sponsored retiree benefits. In fact, most Medicare beneficiaries who do not otherwise have employer-sponsored supplemental coverage, Medicaid, or Medicare+Choice plans purchase a Medigap policy, demonstrating the value of this coverage to the Medicare population.

Medigap Policies Can Have High Cost

Medigap policies can be expensive. The average annual Medigap premium was more than $1,300 in 1999. Premiums varied widely based on the level of coverage purchased. Plan A, which provides the fewest benefits, was the least expensive with average premiums paid of nearly $900 per year. The most popular plans—C and F—had average premiums paid of about $1,200. The most comprehensive plans—I and J—were the most expensive, with average premiums paid around $1,700. (See table 3.)

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[9] The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2000 Annual Survey.

[10] Stephanie Maxwell, Marilyn Moon, and Mesha Segal, Growth in Medicare and Out-Of-Pocket Spending: Impact on Vulnerable Beneficiaries, (Urban Institute, Dec. 2000).

[11] Maxwell, Moon, and Segal.

Table 3: Distribution of Medigap Plans and Annual Premiums Per Covered Life, 1999

Medigap plan	Covered lives (percentage)	Average annual premium earned per covered life
A	.....	$877
B	8.0	$1,093
C	15.9	$1,151
D	3.8	$1,032
E	1.5	$1,067
F	23.4	$1,217
G	1.5	$980
H	1.5	$1,379
I	1.5	$1,704
J	2.7	$1,669
Pre-standard (policies originally sold before July 1992)	32.9	$1,573
Plans in states exempt from plan standards[a]	4.5	$1,405
Total[b]	100.0	$1,322

[a] Massachusetts, Minnesota, and Wisconsin have alternative plans in effect and waivers that exempt them from selling the national standard Medigap plans.

[b] Data reported by insurers to the National Association of Insurance Commissioners (NAIC) do not include plan type for policies representing less than 9 percent of Medigap policy covered lives, with an average paid premium of $1,016. These plans are not included in the plan distribution or average premiums reported in the table.

Source: GAO analysis of data collected by the NAIC from the 1999 Medicare Supplement Insurance Experience Exhibit.

Premiums also vary widely across geographic areas and insurers. For example, average annual premiums in Massachusetts ($1,915) were 45 percent higher than the national average. While varying average premiums may reflect geographic differences in terms of use of Medicare and supplemental services and costs, beneficiaries in the same state may face widely varying premiums for a given plan type offered by different insurers. For example, in Nevada, plan A premiums for a 65-year-old ranged from $446 to as much as $1,004, depending on the insurer. Similarly, in Florida, plan F premiums for a 65-year-old male ranged from $1,548 to $2,123; and in Maine, plan J premiums ranged from $2,697 to $3,612.[12]

Medigap policies are becoming more expensive. One recent study reports that premiums for the three Medigap plan types offering prescription drug coverage (H, I, and J) have increased the most rapidly—by 17 to 34 percent in 2000. Medigap plans without prescription drug coverage rose by 4 to 10 percent in 2000.[13]

A major reason premiums are high is that a large share of premium dollars are used for administrative costs rather than benefits. More than 20 cents from each Medigap premium dollar is spent for costs other than medical expenses, including administration. Administrative costs are high, in part, because nearly three-quarters of policies are sold to individuals rather than groups.[14] The share of premiums spent on benefits varies significantly among carriers. The 15 largest sellers of Medigap policies spent between 64 and 88 percent of premiums on benefits in 1999. The share of premiums spent on benefits is lower for Medigap plans than either typical Medicare+Choice plans or health benefits for employees of large employers. Also, 98 percent of Medicare fee-for-service funds are used for benefits.

Remaining Gaps Leave Beneficiaries at Significant Risk

While Medigap policies cover some costs beneficiaries would otherwise pay out of pocket, Medigap policies have limits and can still leave beneficiaries exposed to significant out-of-pocket costs. Medigap prescription drug coverage in particular leaves beneficiaries exposed to substantial financial liability. Prescription drugs are of growing importance in medical treatment and one of the fastest growing components of health care costs. Medigap policies with a drug benefit are the most expensive yet the benefit offered can be of limited value to many beneficiaries. For example,

- Medigap policies offering drug coverage typically cost much more than policies without drug coverage—the most popular plan with prescription drug cov-

[12] Premium quotes for policies available in 2000 and 2001 from most recently available state guides for consumers on Medigap policies.

[13] Weiss Ratings, "Prescription Drug Costs Boost Medigap Premiums Dramatically," March 26, 2001, at http://www.weissratings.com/NewsReleases/Ins—Medigap/20010326Medigap.htm.

[14] Federal law requires Medigap plans to spend at least 65 percent of premiums on benefits for policies sold to individuals, and 75 percent for policies sold to groups.

erage (plan J) costs on average $450 more than the most popular plan without drug coverage (plan F)—although the benefit is at most $1,250 or $3,000, depending on plan type, and

- under the Medigap plan with the most comprehensive drug coverage, type J, a beneficiary would have to incur $6,250 in prescription drug costs to get the full $3,000 benefit, because of the plan's deductible and coinsurance requirements.

That may explain why more than 90 percent of beneficiaries with one of the standardized Medigap plans purchased standard Medigap plans that do not include drug benefits.[15] Further, Medicare beneficiaries who do not purchase Medigap policies when they initially enroll in Part B at age 65 or older are not guaranteed access to the Medigap policies with prescription drug coverage in most states. Insurers may then either deny coverage or charge higher premiums, especially to Medicare beneficiaries with any adverse health conditions.

The Medigap standard prescription drug benefit differs greatly from that typically offered by employer-sponsored plans for active employees or Medicare-eligible retirees. The Medigap prescription drug benefit has a $250 deductible, requires 50 percent coinsurance, and is limited to $1,250 or $3,000 depending on the plan purchased. In contrast, employer-sponsored plans typically require small copayments of $8 to $20 or coinsurance of about 20 to 25 percent, depending on whether the enrollees purchase generic brands, those for which the plan has negotiated a price discount, or other drugs. Further, few employer-sponsored health plans have separate deductibles or maximum annual benefits for prescription drugs. These plans may also offer enrollees access to discounted prices the plans have negotiated even when the beneficiary is paying the entire cost.

FIRST-DOLLAR COVERAGE THROUGH MEDIGAP DISTORTS MEDICARE'S COST CONTROL FEATURES

Even though Medicare's original design has been criticized as outmoded, it included various cost-sharing requirements intended to encourage prudent use of services. These requirements have also traditionally been features of private insurance. However, Medigap's first-dollar coverage—the elimination of any deductibles or coinsurance associated with the use of specific services—undermines this objective. All standard Medigap plans cover hospital and physician coinsurance, while nearly all beneficiaries with standardized Medigap plans purchase plans covering the full hospital deductible, and most purchase plans covering the full skilled nursing home coinsurance and Part B deductible. First-dollar coverage reduces financial barriers to health care, but it also diminishes beneficiaries' sensitivity to costs and could thus increase unnecessary service utilization and total Medicare program costs.

A substantial body of research clearly indicates that Medicare spends more on beneficiaries with supplemental insurance relative to beneficiaries who have Medicare coverage only. For example, an analysis of 1993 and 1995 data found that Medicare per capita expenditures for beneficiaries with Medigap insurance were from $1,000 to $1,400 higher than for beneficiaries with Medicare only. Medicare per capita spending on beneficiaries with employer-sponsored plans was $700 to $900 higher than for beneficiaries with Medicare only.

Some evidence suggests that first-dollar, or near first-dollar, coverage may partially be responsible for the higher spending. For example, one study found that beneficiaries with Medigap insurance use 28 percent more medical services (outpatient visits and inpatient hospital days) relative to beneficiaries who did not have supplemental insurance, but were otherwise similar in terms of age, sex, income, education, and health status.[16] Service use among beneficiaries with employer-sponsored supplemental insurance (which often reduces, but does not eliminate, cost sharing) was approximately 17 percent higher than the service use of beneficiaries with Medicare coverage only.

Unlike Medigap policies, employer-sponsored supplemental insurance policies and Medicare+Choice plans typically reduce beneficiaries' financial liabilities but do not offer first-dollar coverage. Although there is a wide variety in design of employer-sponsored insurance plans, many retain cost-sharing provisions. Medicare+Choice plans also typically require copayments for most services. Moreover, unlike the tra-

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[15] While less is known about the benefits offered by prestandardized plans that were sold prior to 1992—representing about 30 percent of Medigap enrollment in 1999—one expert estimated that most are likely to have some coverage for prescription drugs but that this coverage is even more limited than that offered by the standardized plans. See Deborah J. Chollet, Mathematica Policy Research Inc., "Medigap Coverage for Prescription Drugs," Testimony before the U.S. Senate Committee on Finance, April 24, 2001.

[16] "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," Christensen and Shinogle, Health Care Financing Review, Fall 1997.

ditional fee-for-service program, Medicare+Choice plans require referrals or prior authorization for certain services to minimize unnecessary utilization.

CONCLUDING OBSERVATIONS

As Congress continues to consider proposals to reform Medicare, it is important to examine all facets of the program and how they relate to other coverage that beneficiaries may have. Current Medicare cost-sharing provisions do not reflect common insurance practices that have evolved over time to promote prudent use and protect beneficiaries from catastrophic care costs. Medigap policies also fail to provide the comprehensive coverage needed by some beneficiaries. In addition, by offering first-dollar coverage, they may undermine incentives for prudent use of Medicare services. In light of how prevailing private sector coverage and practice have evolved, reconsideration of coverage and cost-sharing policies, both within the Medicare program and within any supplemental options that may be available, would be valuable to improve both coverage for beneficiaries and the financial health of the Medicare program.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions that you or Members of the Subcommittee may have.

GAO CONTACTS AND STAFF ACKNOWLEDGMENTS

For more information, regarding this testimony, please contact me or Laura Dummit at (202) 512–7114. Rashmi Agarwal, Susan Anthony, James Cosgrove, Paul Cotton, John Dicken, and Carmen Rivera-Lowitt also made key contributions to this statement.

Chairwoman JOHNSON. Thank you very much, Dr. Scanlon.

Dr. Hogan.

STATEMENT OF CHRISTOPHER HOGAN, PH.D., PRESIDENT, DIRECT RESEARCH, LLC, VIENNA, VIRGINIA

Dr. HOGAN. Madam Chairwoman, Members of the Subcommittee, I am Christopher Hogan. I am an economist. I am an independent consultant in the area of health services research.

I was invited here to deliver this message: Secondary insurance raises Medicare's cost substantially. For Medicare—and I mean the tax-funded portion of Medicare—I estimate that the beneficiaries who have secondary insurance, such as Medigap or employer-sponsored insurance, cost the taxpayers about $1,000 a year more than those who do not, and that is after adjusting for their age and their income and their health status. That is my estimate. It is clearly a round number, but it is consistent with many other estimates of that impact, including estimates by the staff of your own Congressional Budget Office.

In addition to raising the cost of the program, secondary insurance has another impact that is often overlooked in discussions of reforming the Medicare program. Coinsurance and deductibles no longer matter for determining service use for the 90 percent of beneficiaries who have secondary insurance. Let me say that again. Medicare's copayment and deductible structure is essentially irrelevant from an economic standpoint. It helps to determine beneficiaries' Medigap premiums, but it does not really affect them in any other way.

From the beneficiary standpoint, you have to keep three things in mind. First, the people who do not have secondary coverage are poor. Second, those without secondary coverage use less of everything, including preventive care. Third, beneficiaries who have the money and have the opportunity seem to express a strong desire

for first dollar coverage. At least that is my reading of the Medigap market. If you look at what they buy, there is little demand for catastrophic-only policies substantial willingness to pay top dollar for that first dollar coverage and strong evidence of little price-shopping on the part of beneficiaries.

Let me sum it up. Secondary insurance costs the program a lot of money, but beneficiaries like it an awful lot. What are you going to do?

Let me give you two thoughts that you may not hear from other sources. First, it would be completely actuarially fair to charge a lower Part B premium to the beneficiaries who do not have secondary coverage. They cost you $1,000 a head less. You charge them the same amount of money. That is kind of regressive considering these are poor people. It would be actuarially fair. It is probably a little bit difficult to administer, but it would be fair, as I say.

Second, I wanted to bring an idea in front of you that was floated by, of all people, the American Medical Association back in the nineties, as a way of reintroducing economically effective copays and deductibles in the Medicare program, if you wanted to do that.

What the AMA had suggested was essentially a prepaid refundable deductible for the Medicare Program. It is not insurance. It is not a subsidy. I will just give you the bare bones of it.

You could ask beneficiaries to pay an additional amount every month. For the purposes of illustration, I have put forth a rather hefty amount, $80 a month; 80 times 12 is 960 bucks, you would be asking beneficiaries to pay to HCFA. Medicare would then pay the first $960 of copays and deductibles, no muss, no fuss, no secondary insurers, no paperwork. They would simply pay them. If a beneficiary did not use 960 bucks, Medicare would give them their money back, maybe with a nice note thanking them for the use of money over the year. Beneficiaries that used more than 960 bucks, those costs would be covered by the secondary insurers or not, as they are now. This was the only feasible way that I saw to introduce economically rational coinsurance in the Medicare Program, but not put the secondary insurers out of business. In effect, it would work like a little miniature medical savings account, not for all health care, not even for all the copays and deductibles, but for whatever portion of the copays and deductibles that you thought might be reasonable to ask beneficiaries to prepay.

Let me summarize. Secondary insurance raises the program's costs substantially. It disconnects those financial levers that you call copay and deductible and makes them absolutely irrelevant to the typical beneficiary, but beneficiaries like to be fully insured and they will pay top dollar to become fully insured if they have the money to do it. Those who cannot afford to pay, well, they are poor, they are disadvantaged, and they use less of everything, including good services like preventive care.

If you wanted to reintroduce economically important copays and deductibles, economically active copays and deductibles back into Medicare, the only thing I saw that would do that was this prepaid deductible notion. It is very difficult otherwise because whatever you do, secondary insurers fill in the copays and deductibles and make care free.

If you want to consider this, that is great. If you do not and you want to have copays and deductibles that matter, you are going to have to restructure the secondary insurance market because your copayments and deductibles do not matter. They control that now.

Thank you very much.

[The prepared statement of Dr. Hogan follows:]

Statement of Christopher Hogan, Ph.D., President, Direct Research, LLC, Vienna, Virginia

Madam Chairwoman and members of the subcommittee, my name is Christopher Hogan. I'm an economist familiar with the issues of coverage and cost in the Medicare program, having worked almost 10 years on the staff of the Medicare Payment Advisory Commission and the Physician Payment Review Commission. Currently, I am an independent consultant in the area of health services research.

I was asked to talk about the impact of secondary insurance on Medicare beneficiaries' use and cost of services. In the next five minutes, I'd like to make a few points about this, then sketch some possible policies you might pursue. First, I'd like to talk about the impact that secondary insurance has on Medicare program costs. Second, I'd like to talk about some of the beneficiary-oriented aspects of secondary insurance, including impact on use of care. Finally, I'd like to sketch out some potential policy directions you might consider in this area.

The first fact for this discussion is that almost no one actually pays fee-for-service Medicare's copayment and deductible amounts in full. Analysts may quibble about the exact fraction of the Medicare population that has only fee-for-service Medicare and no secondary insurance, but everyone will agree that this fraction is small, on the order of 10 to 15 percent of all non-institutionalized Medicare beneficiaries. The rest have employer-sponsored coverage, individual purchase Medigap, Medicaid, Medicare+Choice, some other coverage or some combination of the above.

Medigap plans by design typically provide first-dollar or very nearly first-dollar coverage, filling in those copayment amounts completely. Employer-sponsored coverage is more of a mixed bag and can be coordinated with Medicare in a variety of ways, but it is increasingly typical for employer-sponsored coverage to fill in only part of Medicare's copayment and deductible amounts. For example, beneficiary financial liability might be limited to the amounts that the employers' policy specifies for active workers.

The second major point I would like to stress is that by filling in Medicare's copayments and deductibles, secondary insurance raises the costs of the Medicare program substantially. Common sense suggests that individuals are more likely to use care if it is free (although "pre-paid" is a better description than "free"). The empirical evidence of this effect is very solid. Numerous researchers using a variety of data sources, methods, populations, and time periods have all shown that removing deductibles and copayments from an unrestricted fee-for-service health plan substantially increases health care use.

This is not news. In addition to research stretching back at least as far as 1972, the impact of secondary insurance on Medicare program costs has been reported by legislative-branch agencies including the Congressional Budget Office and the Physician Payment Review Commission. In fact, the last few years of CBO Budget Options books have included options for restructuring Medicare's copayments and deductibles and for reducing the impact of secondary insurance on Medicare program costs.

Even though there is no particular account or line-item labeled "additional Medicare spending due to secondary insurance", the evidence is so strong that it is not really worth discussing whether or not secondary insurance raises Medicare's costs. Ask any actuary.

We could have some reasonable disagreement on exactly how much the presence of secondary insurance adds to Medicare's costs. The estimates of impact are all based on statistical analyses, and I'm sure that some of you agree with Mark Twain's assessment of statisticians. On a more serious note, we can question whether the statistical analysis adequately controls for factors affecting spending, such as age, health status, income, education and the like. Most analyses of this issue suggest that beneficiaries with secondary insurance cost anywhere between 15 and 30 percent more than beneficiaries with no secondary insurance, after accounting for the factors listed above.

In round numbers, an additional $1,000 per beneficiary per year is a good figure to use when discussing the magnitude of the effect of secondary insurance on the costs of the Medicare program. That's not very precise but it is about the right size,

which I think correctly characterizes the literature on the effect of secondary insurance on Medicare costs.

Most analyses also find that Medigap coverage raises Medicare costs somewhat more than does employer-sponsored coverage. The assumption is that this is a result of the copayment structure: Medigap coverage tends to be first-dollar coverage, but some substantial portion of employer sponsored coverage requires some (reduced) beneficiary copayments. That is a plausible explanation but there is not enough detail in available data sources to provide an easy, direct test of this assumption.

Estimated Impact of Secondary Insurance on Medicare Per-Capita Spending

Insurance Status	Medicare Cost
Medicare+Medigap	$5,400
Medicare+Employer-sponsored	$4,900
Medicare only	$4,000
Memo: Assumed Medicare cost per capita	$5,000

Notes: For ease of presentation, this analysis was based on an assumed Medicare average cost of $5,000 per beneficiary per year. Estimates were adjusted for numerous sociodemographic characteristics, including age, gender, income, education, and health status.
Source: Calculated from PPRC 1997 Annual Report to the Congress, Chapter 15.

Beyond the issue of costs, filling in the deductibles and copayments of fee-for-service Medicare also affects the ability to modernize and improve the traditional Medicare program. Private insurance in many market areas evolved via the PPO model, where individuals are offered modest financial incentives to use preferred providers. Currently, this is the most popular approach for health insurance for the working population. Properly done, modestly higher copayments for out-of-network use are not coercive or hugely restrictive. Instead, subscribers who have no strong preferences about using any particular provider are channeled toward the plan's preferred providers.

Traditional Medicare, by contrast, cannot evolve via that PPO model. Modestly lower copayments for use of preferred providers simply will not work in Medicare because almost no beneficiaries actually pay those copayments in the first place. Medigap plans themselves can adopt this approach (as in Medicare Select), but the Medicare program does not have these financial levers in its control. This tends to put the traditional Medicare program into an evolutionary dead end. It is, to some approximation, an unrestricted fee-for-service program with no copayments or deductibles and no easy path for moving toward alternative approaches to financing care.

Turning now to the beneficiaries, the first fact to absorb is that beneficiaries without secondary insurance are, on average, poorer, more likely to be minority race, and in worse health than the rest of the Medicare population. They can reasonably be characterized as not poor enough for Medicaid, not having had a good enough job to get employer-sponsored coverage, and not well-enough off to want to purchase Medigap. Roughly speaking, the lack of coverage appears driven more by wealth than by health. The disabled (under-65) are also disproportionately represented in this group.

It is worth noting that the cost-increasing effects of secondary insurance are therefore substantially regressive. Medicare costs (and hence the Part B premium) are inflated by better-off beneficiaries who have some secondary insurance. Those without secondary insurance have far lower use of service, but pay a Part B premium that largely reflects the high use of those with complete insurance coverage. In effect, they pay a share of the high costs incurred by better-off, fully-insured beneficiaries.

The second fact to consider is that beneficiaries without secondary insurance consume less of all types of health care services. This includes things that are generally viewed as "good" care, such as preventive services. For five preventive services that can easily be tracked in the 1997 Medicare Current Beneficiary Survey (some physician visit during the year, flu shot, pneumonia shot, mammogram, pap smear), beneficiaries with no secondary insurance had lower use of every service, with use rates ranging from 13 to 30 percent lower than beneficiaries with employer-sponsored or Medigap coverage. (Those use rates were adjusted for differences in age, gender, race, income, health status, and self-reported presence of diseases.)

It is inherently difficult to demonstrate whether or not this has an impact on beneficiaries' health. The definitive study of this issue for the under-65 population was the RAND National Health Insurance Experiment. The conclusion from that research (summarized in the book Free for All by Joseph Newhouse and colleagues) was that modest copayments did not noticeably reduce health status, with the sub-

stantial exception of low income individuals with mental health problems. For the Medicare population, the research is less clear-cut. One study found that individuals without secondary insurance were more likely to move from no disability to some disability (limitation on activity of daily living) over a two-year period, but that the progress to higher levels of disability beyond that occurred at the same rate regardless of secondary insurance coverage. In other studies, some have found no differences in outcomes for specific diseases such as cancers, others have found differences in treatment and outcome.

The third relevant fact about beneficiaries and secondary insurance is the strong desire for complete (first-dollar) coverage, to the point of behavior that economists would label irrational or inefficient. Beneficiaries will indeed pay more than $100 to insure the cost of the Part B deductible. Prior to 1990, in the rare instances when beneficiaries were offered inexpensive catastrophic-only Medigap or expensive first-dollar Medigap, few individuals opted for the catastrophic-only plans. After 1990, faced with standardized Medigap products with wildly varying prices, almost no beneficiaries shopped and switched insurers. In a 1996 report, the GAO estimated that, of individuals owning Medigap policies in 1991 and alive in 1994, only about 1 percent had switched insurers over that three-year period. I do not know whether shopping for policies remains as rare in the Medigap market now as it was then.

The point here is that if you expect beneficiaries to engage in what economists would like to think of as reasonable, rational, efficient behavior toward Medigap coverage, you will be sorely disappointed. Behavior in the Medigap market does not suggest that beneficiaries typically act as cost-minimizing rational shoppers. Instead, behavior far more strongly suggests that beneficiaries want first-dollar coverage regardless, and that once they have it they do not want to change coverage.

Allow me to summarize the points in the presentation so far, then to describe some potential directions for policy.

- Only 10 to 15 percent of beneficiaries have fee-for-service Medicare with no secondary insurance.
- Secondary insurance fills in Medicare's deductible and copayment liabilities, increases use of services, and raises Medicare's costs substantially. A reasonable round number for discussion is that secondary insurance raises Medicare outlays by around $1,000 per beneficiary per year.
- Those without secondary insurance tend to be poorer, in worse health, and are more likely to be minorities.
- Individuals without secondary insurance use less of all types of care, including "good" preventive services. It is difficult to say empirically whether their health does or does not suffer as a consequence of that.
- Behavior in the market for Medigap insurance reveals a strong apparent preference for first-dollar insurance coverage and little evidence of price-shopping.

Given these observations on the Medicare beneficiaries' secondary insurance, what types of policy options could you reasonably consider? Several years ago I engaged in discussions of fairly radical approaches in this area, both at the Physician Payment Review Commission and in testimony to the National Bipartisan Commission on the Future of Medicare. These proposals included banning or taxing Medigap, or requiring Medigap insurers to become full-risk plans under Medicare+Choice. My impression from that earlier experience was that even if the potential cost and cost savings are as exactly as stated above, few would be willing to risk the disruptions that such radical changes might create. Based on my earlier experience, I will limit my suggestions in this testimony to more incremental approaches that would not eliminate Medigap insurance.

Discussion of the issues centers around which concerns you are trying to address. Is your interest on the cost-increasing effects of secondary insurance? Is your concern with the well-being of the 10 to 15 percent who have no secondary coverage? Or is concern on the high prices that beneficiaries and employers must pay to obtain that secondary insurance coverage?

First, I would like to draw your attention to the February 2001 CBO Budget Options book, where there is a short discussion of budget-neutral restructuring of Medicare's copayment and deductible liabilities. In particular, they show a restructuring that would provide maximum out-of-pocket protection for Medicare beneficiaries and generate some small cost savings for Medicare. Nothing is free: in order to provide a stop-loss provision of $2,000, the CBO option would require a combined A/B deductible of $1,000 and a 20 percent copayment for all care above the deductible. So, discussion can start from that basis. It is absolutely feasible to limit beneficiaries' total out-of-pocket costs for Medicare-covered services to $2,000 annually, in exchange for higher payments for care below that catastrophic cap.

A second option would be to try to offer some sort of advantage to that 10 to 15 percent of beneficiaries who have no secondary insurance coverage. It would certainly be fair to offer them a lower Part B premium, since their spending is substantially below that of other beneficiaries. From an actuarial standpoint, that's reasonable. From an operational standpoint, having beneficiaries sign up for this, certify that they don't have secondary insurance, and receive a reduced or zero Part B premium in response is likely to be a difficult system. Hence, this option probably has more theoretical than practical merit.

A third option focusing on those without secondary insurance would be to eliminate Medicare copayment liabilities on selected preventive services. For example, if good health care requires that beneficiaries see a doctor at least once a year, then Medicare could make that first office visit free. This type of approach is likely to have a very high cost per net new preventive service delivered. Not only would it make services free for the vast majority of beneficiaries who have secondary insurance, research shows that most beneficiaries will not obtain preventive care at the recommended rates even when it is free. Thus, the likely cost per additional preventive service actually delivered to those without secondary insurance is likely to be high.

A fourth option would be to take a new benefit design and impose it on the Medigap industry, either for existing policies or, more likely, for all newly-issued policies. For example, first dollar coverage could be replaced by a low and simple copayment structure (e.g., $10 per office visit), while again certain key items of preventive care might be covered in full. This would not achieve the technical efficiencies potentially available in a federally-run alternative (such as paperwork reduction and elimination of overhead costs), but would not displace the current private-sector providers of such insurance. Applying the restructured benefits only to newly issued policies would avoid disrupting Medigap insurers' ongoing lines of business.

In any revised Medigap benefit structure, there has to be some caution about paperwork burden relative to amounts collected. The cost of the paperwork for small copayment amounts may exceed the cost of the copayments. The current first-dollar Medigap system typically results in two financial transactions per service when the Medigap insurer's systems are coordinated with Medicare's. There is a large payment from Medicare to the provider, and a smaller payment from the Medigap insurer to the provider, with the Medicare carrier passing along the bill for the copayment directly to the Medigap insurer. Adding yet a third, even smaller payment directly from the beneficiary to the provider may increase the overall administrative burden of the system unless that payment is very simply structured and is routinely handled at the time of the service, such as a flat $10 copayment per visit.

Finally, I would like to mention an option that was developed in the mid-1990s by the American Medical Association. They proposed a plan that amounted to a prepaid, refundable deductible for Medicare, in effect creating a small Medical Savings Account (MSA) within Medicare for each beneficiary. Beneficiaries would pay an additional monthly premium of (say) $80 to Medicare. All Medicare copayment and deductible liabilities for the year below $960 (80 x 12) would be paid from this prefunded amount, with no paperwork burden involved. Beneficiaries with under $960 in copayment/deductible liabilities would receive a refund at year-end (similar to an MSA). Those with copayment/deductible liabilities in excess of this amount would pay them as in the current Medicare program. Secondary insurers would be free to cover copayment/deductible liabilities in excess of this $960 limit, but would never see anything below the $960 limit. Employers or others would be free to pay the beneficiary's $80 monthly premium. In effect, this proposal would take the first $960 of current copayment and deductible liabilities and simply make them off-limits to secondary insurers, handling them internally within Medicare instead.

This proposal provides a potential efficiency-versus-equity tradeoff. On the efficiency side, it reduces but does not eliminate the role of secondary insurers and the paperwork burdens from copayment/deductible liabilities. The potential for a rebate provides incentive to constrain use of care (as in an MSA). (If third parties paid the monthly premium and collected any year-end rebate, that would nullify incentives for reduced use of care.) But like the MSA proposal, this approach reduces pooling of risks. Healthy beneficiaries would pay the least and those with high use of care would face an effective $960 deductible, plus any copayment liabilities incurred excess of that (if any). The overall tolerance for this efficiency-versus-equity tradeoff could be fine-tuned by lowering or raising the amount of the prepaid, refundable deductible.

In conclusion, there are few obvious alternatives for restructuring Medicare copayments, liabilities, and secondary insurance. First-dollar coverage from secondary insurance raises Medicare costs and is probably not the most efficient way to struc-

ture payment. Yet, beneficiaries' demand for Medigap reveals a strong desire for such coverage. Reworking Medigap to require small copayments for each service would likely be unpopular and might increase paperwork burden disproportionate to the amounts of money involved. As CBO has demonstrated, we could restructure Medicare rather than restructure Medigap, protecting beneficiaries from catastrophic costs at the expense of higher payments from non-catastrophic users. A final alternative that seems plausible is to create, in effect, a mini-MSA for the first few hundred dollars of Medicare copayment/deductible liabilities. This might allow some reductions in overhead and paperwork burdens (and possibly some reduction in service use) without eliminating the private provision of secondary insurance.

Chairwoman JOHNSON. Thank you, Dr. Hogan.
Dr. Davis.

STATEMENT OF KAREN DAVIS, PH.D., PRESIDENT, COMMONWEALTH FUND, NEW YORK, NEW YORK

Dr. DAVIS. Thank you, Madam Chairman, Mr. Stark, Members of the Subcommittee for this invitation to testify on Medicare's cost sharing.

I think it is important to remember that Medicare was created in 1965 to ensure financial protection for older Americans against the cost of medical expenses and to ensure access to quality health care. Modernizing Medicare's benefit should involve adding prescription drugs and reducing the burdensome deductibles and cost sharing that we have heard about this afternoon.

Remember that Medicare beneficiaries already spend a high proportion of their income on health care. Last year, the average elderly Medicare beneficiary spent over $3,000 per person on health care expenses, or 22 percent of income. By 2025, that figure will increase to 30 percent of income.

We should also remember that Medicare beneficiaries are sick or poor. Two out of three either have serious health problems or incomes below twice the poverty level. In fact, one-third of Medicare beneficiaries are cognitively impaired or have serious physical limitations, and those third account for 60 percent of all Medicare outlays.

Cost sharing has risen more rapidly than both inflation and the incomes of beneficiaries, eroding the protection that the program was designed to provide. If Medicare's 1966 cost sharing had only risen with general inflation, today's Part A deductible would be $218, not almost $800, and the Part B annual premium would be $196, not $600.

The sickest beneficiaries or those without good supplemental insurance bear the heaviest brunt of out-of-pocket spending. Medicare cost sharing contributes to beneficiary access and bill problems, especially for lower income beneficiaries. Two out of five beneficiaries who are most at risk report either problems obtaining needed services or problems paying their medical bills. Cost sharing and the absence of supplemental insurance contribute significantly to failure to obtain preventive services and proper management of chronic conditions.

Medicare cost sharing is higher than typical employer plans. Non-elderly Americans spend 9 percent of their incomes on health care, compared with 22 percent for elderly beneficiaries.

Deductibles and premiums under employer plans are lower than they are in Medicare, and as we have heard today, they typically include catastrophic ceilings. They also cover physical exams and prescription drugs, which Medicare does not.

Despite this, in fact, Medicare beneficiaries report higher satisfaction with Medicare than working families do with employer coverage.

Medicare beneficiaries need supplemental insurance coverage, but it is increasingly unaffordable or unavailable. As we have heard, 9 out of 10 have supplemental coverage, but Medigap premiums are expensive, over $100 a month, and for some plans in some geographic areas as high as $3,000 a year. Employers are cutting back on retiree coverage, and Medicare Plus Choice enrollment is dropping.

There are a number of options for improving Medicare benefits and reducing cost sharing. In a report being released today by my organization, The Commonwealth Fund, Marilyn Moon and colleagues and the Urban Institute simulate the impact on beneficiaries of improving Medicare benefits and cost sharing. Under all four of the options simulated, both the elderly and the disabled would experience a reduction in total out-of-pocket expenses, including private insurance premiums. Savings would be greatest for beneficiaries with serious health problems. It would reduce the percent of income from 22 percent to 20 percent or, in one option, down to 16 percent. By eliminating or reducing the need for private supplemental insurance, efficiency and coverage would be improved. State Medicaid programs would also be expected to benefit because they now pick up many of these costs for low-income beneficiaries.

Finally, Medicare beneficiaries have a claim on a portion of the budget surplus. As you know well, the Balanced Budget Act achieved major savings largely from the Medicare Program. Together, the slowdown in Medicare and Medicaid outlays in the late nineties account for $1 trillion out of the $5.6-trillion 10-year budget surplus. More than $50 billion of the 10-year budget surplus is attributable to the higher premiums that were part of the 1997 Balanced Budget Act. Returning this contribution to beneficiaries in the form of the improved benefits and reduced cost sharing is worthy of consideration.

Thank you.

[The prepared statement of Dr. Davis follows:]

Statement of Karen Davis, Ph.D., President, Commonwealth Fund, New York, New York

Thank you, Madam Chairman, Mr. Stark, and members of the committee, for this invitation to testify on Medicare's cost-sharing. Medicare provides health insurance for 40 million elderly and disabled beneficiaries. The program was created in 1965 to provide older Americans with financial protection against the cost of medical expenses and to ensure access to quality health care. At the time, half of the elderly were uninsured, since few had retiree coverage through work or could afford private coverage on their own. Today, nearly all of the elderly have basic coverage through Medicare.

However, Medicare's cost-sharing has risen more rapidly than inflation and the incomes of beneficiaries, eroding the protection Medicare was designed to provide. In 2000, the average elderly Medicare beneficiary spent $3,142 on their own health

care expenses, or nearly 22 percent of income.[1] By 2025, that will increase to $5,248 (in constant 2000 dollars)—almost 30 percent of income. Financial burdens on beneficiaries need to be reduced, not increased.

Medicare Beneficiaries are Disproportionately Poor and Sick

Some argue that Medicare cost-sharing is necessary to encourage beneficiaries to be cost-conscious when making choices about their health care. Any discussion of restructuring Medicare cost-sharing should be firmly rooted in an understanding of the characteristics of beneficiaries, their financial contributions to their care, and the difficulties they have obtaining access to care and paying medical bills.

Two of three Medicare beneficiaries are either sick or poor.[2] Of all groups in society, they are perhaps the least able to "help the market work" by making cost-conscious choices. Eleven million beneficiaries have less than a high school education. One-third of Medicare beneficiaries are cognitively impaired or have serious physical limitations;[3] these beneficiaries account for 60 percent of all Medicare outlays. Included in this figure are over 9 million beneficiaries who are cognitively impaired, accounting for 42 percent of Medicare outlays. One and a half million Medicare beneficiaries are in nursing homes.[4] Terminal illness strikes 2.4 million beneficiaries each year. The majority of beneficiaries suffer from a chronic condition such as diabetes, arthritis, heart disease, cancer, or recurrent stroke. Three-fourths must regularly take prescription drugs.[5]

Beneficiaries with the lowest incomes are also the sickest. Over half of those with incomes below the poverty level ($8,259 for a single elderly person in 2000, $10,409 for a couple) are in fair or poor health. One-fourth of the poor need assistance with at least one activity of daily living, such as eating or bathing.

Medicare Beneficiary Cost-Sharing is High

When Medicare began in 1966, the major expenses for which beneficiaries were responsible were the average cost of the first day of hospital care under Part A, a deductible for Part B physician and other ambulatory services, 20 percent coinsurance for Part B services (plus any physician charges over the allowed fees), and a Part B premium. Even adjusting for inflation, today's Part A hospital deductible and Part B premium are three to four times higher than they were in 1966. The rapid growth in the Part A deductible reflects changes in health care technology that have led to shorter but more intensive hospital stays, driving up the average daily cost. Only the Part B deductible is lower today in real terms than it was in 1966. If these cost-sharing amounts had remained constant, adjusted for inflation, today's Part A deductible would be $218, not $792; the Part B deductible would be $272, not $100; and the Part B annual premium would be $196 ($16 a month), not $600.[6]

These cost-sharing amounts or the supplemental insurance premiums required to cover them represent significant financial burdens on Medicare beneficiaries. In 2000, elderly Medicare beneficiaries spent, on average, $3,142 out-of-pocket on health care. About half of this amount came from cost-sharing for covered services or private supplemental insurance premiums to pick up costs not covered by Medicare. About one-fifth is Part B premiums, and the remaining 30 percent is for services not covered by Medicare, primarily prescription drugs.

Despite Medicaid and other programs to subsidize Medicare cost-sharing and premiums for low-income beneficiaries, burdens on low-income beneficiaries are particularly heavy. The poorest beneficiaries spend 30 percent of income on health care. Only 40 percent of low-income beneficiaries eligible for Medicaid and other programs (Qualified Medicare Beneficiaries (QMB), Supplemental Low Income Medicare Bene-

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[1] Stephanie Maxwell, Marilyn Moon, and Misha Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

[2] Patricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Michelle Kitchman, Elaine Puleo, and Drew Altman, "Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform," *Journal of Aging and Social Policy*, 10(4), pp. 25–30, 1999.

[3] Marilyn Moon and Matthew Storeygard, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems*, The Commonwealth Fund, May 2001.

[4] National Center for Health Statistics, *Health, United States, 2000*, HHS/CDC/NCHS, July 2000.

[5] Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland, *Medicare Beneficiaries: A Population at Risk—Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, Henry J. Kaiser Family Foundation and The Commonwealth Fund, December 1998.

[6] Author's calculations based on average inflation rates applied to the original deductibles and premium.

ficiaries (SLMB), Qualified Individuals) participate.[7] Outreach efforts to inform and enroll eligible beneficiaries have been limited.

A study by Marilyn Moon and colleagues at the Urban Institute supported by The Commonwealth Fund modeled average out-of-pocket costs for six cohorts of beneficiaries to illustrate how widely costs vary depending on health and income. For each group, the estimates provide averages given the groups' likely health expenses. The six groups include:

- All elderly
- Elderly with physical or cognitive health problems with no supplemental coverage
- Disabled beneficiaries ages 45 to 64
- Beneficiaries ages 65 to 74 with incomes above $50,000 and employer-sponsored supplemental coverage
- Women with QMB coverage
- Women age 85 and older with physical or cognitive health problems and incomes between $5,000 and $20,000.[8]

Out-of-pocket spending as a percent of income ranges from 6 percent for younger, higher-income beneficiaries with employer supplemental coverage to 52 percent for older women in poor health with limited incomes. It averages 22 percent for all elderly, and 29 percent for disabled ages 45 to 64. On a per capita basis, expenses average $3,142 for all elderly beneficiaries, and $3,870 for disabled beneficiaries ages 45 to 64. They reach as high as $4,815 for those elderly in poor health with no supplemental coverage, and $5,969 for older, low-income women in poor health. These are staggering amounts for a retired population with little income and limited savings.

Medicare Cost-Sharing Contributes to Beneficiary Access and Bill Problems

Not surprisingly, Medicare's cost-sharing affects access to care. This is particularly true for lower-income beneficiaries and for those with serious health problems. The Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries found that about 15 percent of Medicare beneficiaries experience difficulty obtaining needed care.[9] Almost one-fourth of those with incomes below the poverty level have access problems, as do one-third of the disabled under age 65. Problems paying medical bills were reported by 14 percent of all beneficiaries, by one-fourth of those below poverty, and by nearly one-third of the disabled under age 65.

About two of five of the most at-risk beneficiaries reported either difficulties obtaining needed services or problems paying medical bills. This includes 41 percent of those with incomes below the poverty level, 39 percent of those in fair or poor health, 47 percent of the disabled under age 65, and 40 percent of those needing help with one or more activities of daily living.

Financial barriers to health care particularly affect use of preventive care. A 1995 study supported by The Commonwealth Fund found that elderly women were less likely to receive a mammogram if they did not have supplemental health insurance coverage.[10] Medicare has since covered mammograms without subjecting services to the Part B deductible.

The absence of coverage for prescription drugs, however, continues to lead to underutilization of services and inadequate maintenance of chronic conditions. A 2000 study supported by The Commonwealth Fund found that absence of supplemental coverage for prescription drugs was a major reason why many Medicare beneficiaries with hypertension fail to receive appropriate medication.[11]

Rates of hospital admissions that could have been prevented with better preventive or primary care are particularly high for poor and minority elderly—indicating inadequate access to primary care. In sum, poor and near-poor elderly are more likely to experience health problems that require medical services than elderly people who are economically better off. Yet they are less able to afford needed care because of their lower incomes.

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[7] Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

[8] Stephanie Maxwell, Marilyn Moon, and Misha Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

[9] Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland, *Medicare Beneficiaries: A Population at Risk,* The Commonwealth Fund, December 1998.

[10] Janice Blustein, "Medicare Coverage, Supplemental Insurance, and the Use of Mammography by Older Women," *New England Journal of Medicine* 332:1138–1143, April 27, 1995.

[11] Jan Blustein, "Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension," *Health Affairs* 19 (March/April 2000):219–230.

Medicare Cost-Sharing is Higher than Typical Employer Plans

Nonelderly Americans spend about 9 percent of their income on health care—much less than what the elderly spend.[12] In large part, this reflects extensive employer-sponsored health insurance with lower cost-sharing, and better benefits. Most employer plans include a ceiling on out-of-pocket expenses; Medicare does not. In the generosity of its benefit package, Medicare ranks in the bottom decile of insurance plans.

The average deductible for all services—including hospital, physician, and other services—is $239 in conventional fee-for-service plans offered by employers.[13] Deductibles are even lower in managed care plans including preferred provider option (PPO) plans and point-of-service (POS) plans, and are virtually nonexistent in health maintenance organizations (HMOs). The typical ceiling on out-of-pocket expenses in conventional employer plans is $1,500. Benefits are substantially more comprehensive: 71 percent of firms cover adult physical exams, which Medicare does not; 87 percent cover prescription drugs; and 25 percent cover dental care. Employers pick up, on average, 86 percent of the premium for single coverage for workers, leaving the worker with a monthly premium share of $28. In contrast, a Medicare beneficiary's monthly premium share is $50 (on top of Medigap premiums that average over $100 a month).

Over an individual's lifetime, health care expenses are greatest after reaching retirement, when incomes are lower and savings are being drawn down. Improving Medicare benefits—even if financed by greater contributions during the working years—would smooth lifetime health spending patterns and afford greater economic security in older age.

Despite the fact that Medicare's benefits do not compare favorably with employer coverage, it is noteworthy that Medicare beneficiaries report higher satisfaction with Medicare than do working families with their own coverage. Fifty-seven percent of Medicare beneficiaries say they are very satisfied with Medicare, compared with 46 percent of working families covered by employer health insurance.[14]

A Commonwealth Fund survey of 50-to-70-year-old adults finds strong support for Medicare.[15] Older adults trust Medicare and value its reliability. Nearly two-thirds of all adults 50 to 64 would like the option of buying into Medicare early, while 86 percent of uninsured older adults would like that option. Preference for Medicare may reflect the predominance of the program's fee-for-service option; most employer plans are limited to one or more managed care plans. But it may also reflect an appreciation for the fact that Medicare will be there for them over time, as well as a concern that private coverage may be unavailable or unaffordable when serious illness or disability strikes or when older adults are no longer able to work.

Supplemental Coverage Needed by Medicare Beneficiaries

While workers with employer health insurance rarely purchase supplemental coverage, nine of 10 Medicare beneficiaries obtain supplemental coverage to augment Medicare's benefits. About 38 percent of Medicare beneficiaries have supplemental coverage from a current or former employer.[16] About 23 percent are covered by individually purchased private supplemental insurance (Medigap), 15 percent are enrolled in Medicare+Choice plans, and 13 percent are covered in part or in full by Medicaid. About one of 10 Medicare beneficiaries are covered by traditional Medicare only. The ability of Medicare beneficiaries to supplement Medicare's benefit with additional coverage is undoubtedly a factor in the high satisfaction with Medicare reported by beneficiaries. On the other hand, the widespread need for supplemental coverage attests to the perceived inadequacy of the Medicare benefit package.

Not all Medicare beneficiaries are able to afford supplemental coverage, nor is coverage with prescription drug benefits available to those with serious health problems. A recent study by a team of investigators at the University of California, Los Angeles, that was supported by The Commonwealth Fund reported that 17 percent of beneficiaries with incomes below $10,000 had no supplemental coverage, com-

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[12] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, Medical Expenditure Panel Survey, 1996.

[13] Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits, 2000 Annual Survey*.

[14] Henry J. Kaiser Family Foundation and The Commonwealth Fund, *Working Families at Risk: Coverage, Access, Costs, and Worries,* Kaiser/Commonwealth 1997 National Survey of Health Insurance, December 1997.

[15] Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis, *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70,* The Commonwealth Fund, July 2000.

[16] Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

pared with 5 percent of those with incomes above $25,000.[17] Similarly, employer-sponsored supplemental coverage is much lower as is Medigap coverage for lower-income beneficiaries.

Nor does supplemental coverage always include prescription drug benefits. Only half of Medicare beneficiaries have year-long supplemental prescription drug coverage.[18] Prescription drug coverage is quite expensive, and Medigap plans that cover drugs (Plans H–J) are subject to underwriting and exclude beneficiaries who are deemed poor health risks. In 2000, Medigap annual premiums for Plan J, including prescription drugs, averaged $3,252 for a 65-year-old woman.[19] Even Plan E plans that exclude prescription drugs average annual premiums of $1,320 ($110 a month)—an amount on top of Medicare Part B premiums that are now $600 a year. While standardization of Medigap policies has reduced confusion, not all plans are in compliance with federal standards on the ratio of benefits to premiums and many plans offer poor value at high cost.[20]

Most disturbing is the trend in future coverage. Eighty-one percent of employers report that they are planning to increase retiree health premiums and/or cost-sharing in the future, and 40 percent are cutting back on prescription drugs.[21] Thirty percent are planning to terminate coverage for future retirees.

Medicare+Choice plans have enrolled about 6 million beneficiaries. Better benefits and lower cost-sharing are major reasons why beneficiaries choose managed care plans. But instability in the managed care market and the withdrawal of plans either nationally or from selected geographic areas raise questions about the long-term future of this option. Medicare+Choice plans are increasing monthly premiums and reducing benefits, especially prescription drug benefits.[22] As a result, the number of beneficiaries enrolled in Medicare+Choice peaked in 1999 at 6.3 million; such plans now cover 5.6 million people.

If private market trends continue, Medicare beneficiaries will be increasingly reliant on the individual, Medigap market to supplement Medicare's basic benefits. There are now signs that premiums in this market—where costs cannot be pooled through employer groups or managed care health plans—are beginning to spiral upward for policies that include prescription drug coverage (and that already feature high administrative costs). Further increases may well expand the proportion of beneficiaries who can afford only basic Medicare benefits.

Options to Improve Medicare Benefits and Reduce Cost-Sharing

Given the increasing unreliability of supplemental coverage and the serious financial burdens and barriers to needed care that Medicare beneficiaries face, consideration should be given to improving Medicare's benefits. In a Commonwealth Fund-supported study by Marilyn Moon and colleagues at the Urban Institute being released today,[23] four options for improving Medicare's benefit package are simulated:

- Option 1 combines Part A and Part B, replaces the current deductibles with a single combined annual deductible of $400, and introduces a $3,000 annual beneficiary limit on cost-sharing and deductible expenses. It would increase Medicare outlays by an estimated $3.2 billion in 2000.
- Option 2 reduces the Part A deductible to $200 per spell of illness and increases the Part B deductible to $200. Part B coinsurance is reduced to 10 percent, a new 10 percent coinsurance on home health services is introduced, and all cost-sharing and deductible expenses are subject to a $2,000 annual beneficiary limit. This option would increase Medicare outlays by an estimated $16.4 billion in 2000.
- Option 3 eliminates the Part A deductible and all Part A cost-sharing. While increasing the Part B deductible to $200, it eliminates Part B coinsur-

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[17] Nadereh Pourat, Thomas Rice, Gerald Kominsky, and Rani E. Synder, "Socioeconomic Differences in Medicare Supplemental Coverage," *Health Affairs* 19 (September/October 2000).

[18] Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, The Commonwealth Fund, January 2000.

[19] Quotesmith.com, as cited in Marilyn Moon, *Assessing the President's Proposal to Modernize and Strengthen Medicare*, The Commonwealth Fund, January 2000.

[20] General Accounting Office, *Medigap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards, 1988–93*, August 12, 1995; and Lutzky, Alecxih, Pankaj, Laud, and Schaab, *Restricting Underwriting and Premium Rating Practices in the Medigap Market: The Experience of Three States*, AARP Public Policy Institute, January 2001.

[21] McArdle, Coppock, Yamamoto, and Zebrak, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, Hewitt Associates, October 1999.

[22] Marsha Gold and Lori Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001*, The Commonwealth Fund, April 2001.

[23] Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

ance. This improved coverage is financed by increasing the Part B premium to $105 per month, achieving virtual budget-neutrality.

• Option 4 adds a prescription drug benefit with 50 percent coinsurance, a $2,500 limit on beneficiary cost-sharing, and a $26 monthly premium. This option would increase Medicare spending by $13.9 billion in 2000.

The first three options reduce out-of-pocket spending by improving covered Medicare benefits and/or reducing or eliminating the need to purchase costly Medigap coverage. The fourth option introduces coverage for a currently uncovered benefit, prescription drugs, and could be combined with any one of the first three options.

Under all four options, both the elderly and the disabled would experience a reduction in total out-of-pocket expenses, including private insurance premiums, cost-sharing for covered services, and expenses of noncovered services. The elderly would save $27 per capita under Option 1, $240 under Option 2, and $763 under Option 3. Disabled beneficiaries ages 45 to 64 would save $103, $280, and $408, respectively, under Options 1, 2, and 3. The disabled would particularly benefit from a prescription drug benefit: Option 4 would save the elderly $181 per person, while the disabled ages 45 to 64 would save $824 per person.

Savings would be greater for beneficiaries with serious health problems. The Urban Institute team estimates that elderly beneficiaries in poor health without supplemental coverage would save $285, $587, and $1,591 per person, respectively, under Options 1, 2, and 3. For low-income women over age 85 and in poor health, savings would be even greater—$495, $753, and $2,092.

On average, out-of-pocket spending for elderly beneficiaries would decline from the current rate of 21.7 percent of income to 21.5 percent under Option 1, 20.0 percent under Option 2, and 16.4 percent under Option 3. Option 4, if enacted alone, would reduce spending to 20.4 percent of income.

Option 3, by eliminating the need for private supplemental insurance, represents an important way to improve efficiency in coverage for Medicare beneficiaries. Consolidating coverage under Medicare produces savings through reduced administrative costs by eliminating the need to coordinate two sources of coverage. Medicare administrative costs are also lower than private insurance plans. Medicare does not need to maintain reserves to protect against adverse risk selection, nor are marketing or sales commissions needed.

Some beneficiaries, however, could face higher costs. About 20 percent of Medicare beneficiaries are hospitalized in a given year.[24] Under Option 1, replacing the current Medicare Part B $100 deductible with a combined A/B deductible of $400 would result in higher costs for the 80 percent of beneficiaries without a hospital episode during the year. For beneficiaries lacking supplemental coverage, the immediate effect would be a substantially higher overall deductible.

Similarly, for retirees with employer-sponsored coverage, much depends on how employers respond to improved Medicare benefits. If employers pick up the higher Part B premiums under Option 3, most beneficiaries with retiree coverage would gain. If any savings to employers were devoted to improving other benefits (such as prescription drugs), beneficiaries would gain further. But employers could use the improvement in Medicare benefits as an opportunity to drop retiree coverage even more rapidly than is currently anticipated.

State Medicaid programs would also be expected to benefit from an improvement in Medicare benefits. This is particularly true under Option 4 with the addition of prescription drugs to Medicare, a benefit now covered by most Medicaid programs. But the reduced cost-sharing under Options 1, 2, and 3 would also provide fiscal relief to state governments. Improved Medicare benefits might be coupled with increased state responsibility for coverage of low-income families under Medicaid or the Children's Health Insurance Plan.

Conclusion

For more than 35 years, the Medicare program has assured health and economic security for older and disabled Americans. Understanding the strengths of the program and its contributions to improving health outcomes and access to health services is an important foundation on which to build.

Medicare beneficiaries are heterogeneous. Some fit the stereotype of vigorous and well-to-do seniors. But others are older widows living alone, some are in nursing homes, some are terminally ill, and some live on quite modest incomes. These are the faces of Medicare, and they should be kept foremost in mind as new ideas for modernizing Medicare's benefits are developed and considered. Improving Medi-

[24] U.S. House of Representatives, Committee on Ways and Means, *2000 Green Book,* October 6, 2000.

care's benefits—not just looking for savings or shifting costs to beneficiaries—should be an important priority.

Reducing the financial burden beneficiaries already bear, as well as the increasing burden they are expected to face over the next 25 years, should be a priority for use of federal budget outlays. We should remember that a considerable portion of the federal budget surplus was generated by the Balanced Budget Act (BBA). An estimated $1 trillion of the $5.6 trillion 10-year surplus was derived from a slow-down in Medicare outlays, in large part as a result of BBA, and from the slow-down in Medicaid outlays, an unintended consequence of welfare reform.[25]

Ten percent of the Medicare BBA savings came from increased beneficiary premiums, as home health services were moved from Part A to Part B and subjected to 25 percent beneficiary premium contributions.[26] For example, the Part B premium in 2006 was raised more than 50 percent by the BBA. As a result of the BBA, over $50 billion of the 10-year budget surplus was from higher premiums charged to Medicare beneficiaries. Returning this contribution to beneficiaries in the form of improved benefits and reduced cost-sharing is worthy of consideration.

Thank you for this opportunity to testify. I would be pleased to answer any questions.

Medicare's Cost Sharing: Implications for Beneficiaries

Karen Davis

President, The Commonwealth Fund

U.S. House Committee on Ways and Means
Subcommittee on Health

Strengthening Medicare:
Modernizing Beneficiary Cost-Sharing

May 9, 2001

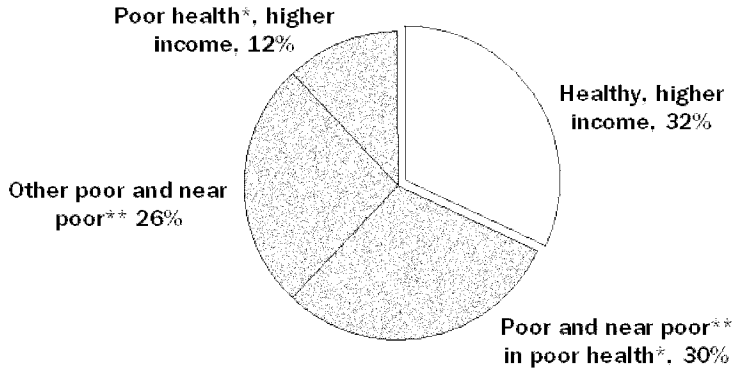
[25] Karen Davis, Cathy Schoen, and Stephen C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medicine*, 260, December 11/25, 2000.

[26] Marilyn Moon, Barbara Gage, and Alison Evans, *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997*, The Commonwealth Fund, September 1997.

Medicare and Beneficiary Protection

- **Primary source of health insurance for 39.5 million elderly and disabled beneficiaries in 2000; 70 million beneficiaries projected in 2025**
- **Medicare was designed to ensure financial protection to beneficiaries and access to care**
  - **Despite this, out-of-pocket spending for elderly beneficiaries will increase from $3,142 in 2000 to $5,248 in 2025 in constant 2000 dollars**
  - **Out-of-pocket spending will increase as a percent of income from 21.7% in 2000 to 29.9% in 2025**

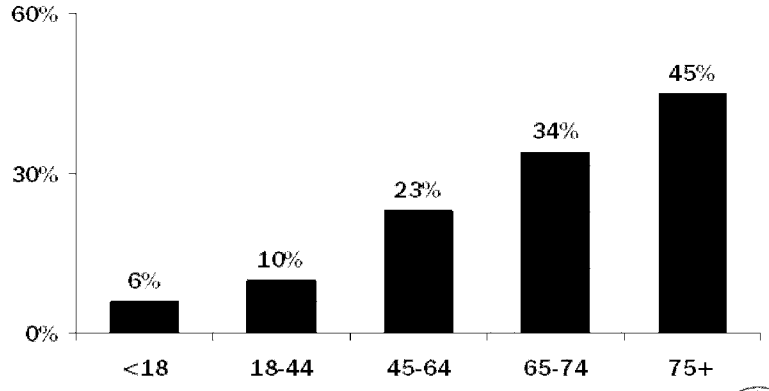
Two in Three Medicare Beneficiaries have Health Problems* or Live on Low Incomes



*In fair or poor health or disabled, under age 65.
**Near poor include those with incomes between 100 and 199% of the Federal Poverty Level.
Source: Schoen, Neuman, Kitchman, Davis, and Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.

Likelihood of Chronic Conditions Increases with Age

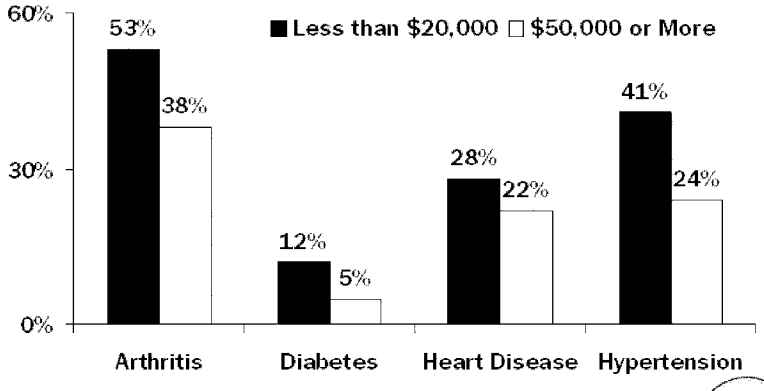
Percent limited in activities because of chronic conditions



Source: Laura Trupin and Dorothy Rice, *Health Status, Medical Care Use, and Number of Disabling Conditions in the United States*, Disability Statistics Abstract Number 9 (June 1995), National Institute on Disability and Rehabilitation Research.

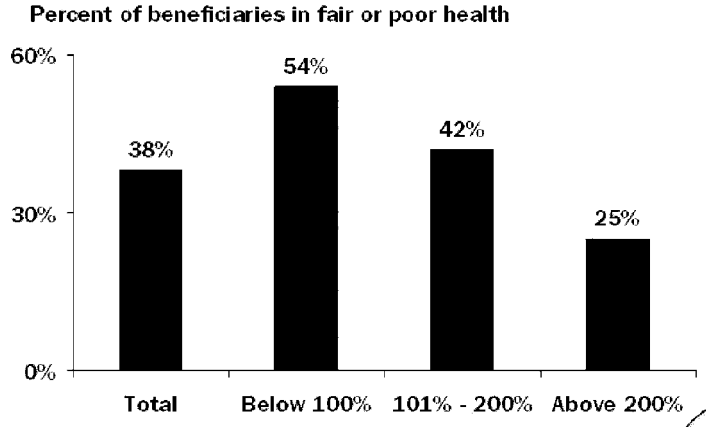
Low-Income Elderly Face Higher Risk of Chronic Conditions

Percent of adults age 65 and over with a chronic condition



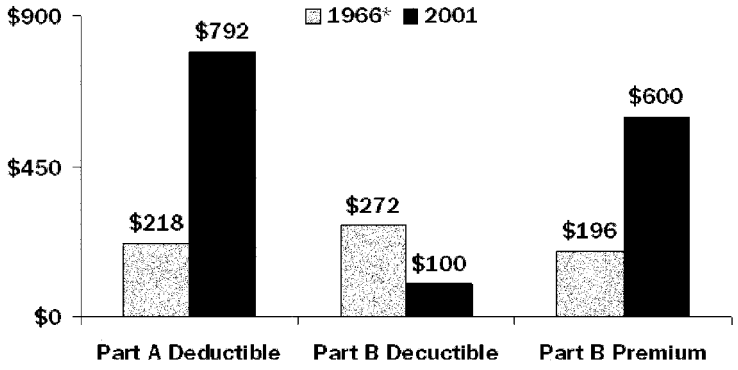
Source: National Academy on an Aging Society analysis of 1994 National Health Interview Survey data.

Medicare Beneficiaries in Fair or Poor Health, by Poverty Status, 1997



Source: Schoen, Neuman, Kitchman, Davis, and Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.

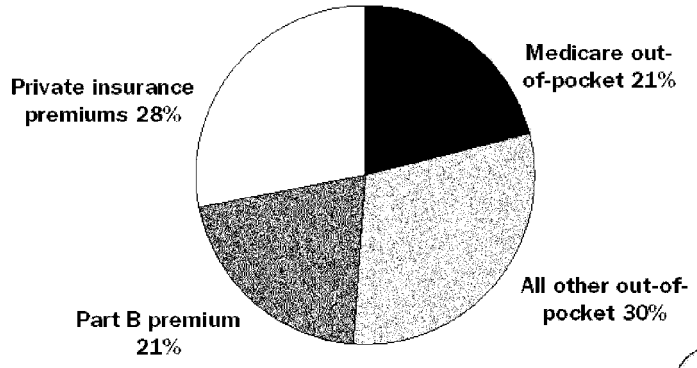
Medicare Cost Sharing, 1966 and 2001



*1966 figures are in 2001 dollars.
Calculated by Karen Davis based on Bureau of Labor Statistics CPI data and HCFA, Office of the Actuary.

Out-of-Pocket Health Expenditures for the Non-Institutionalized Elderly, 2000

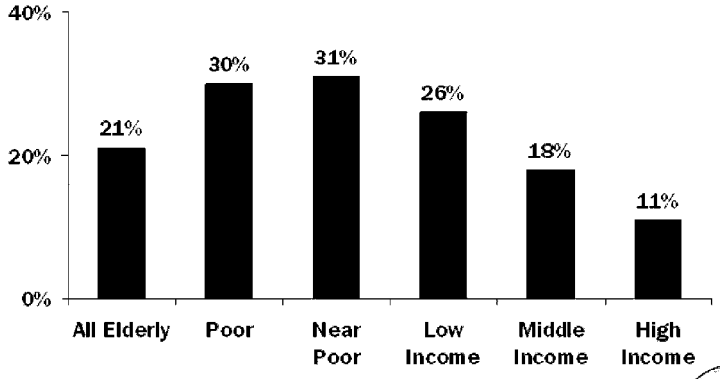
$3,142 per beneficiary



Source: Maxwell, Moon, and Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

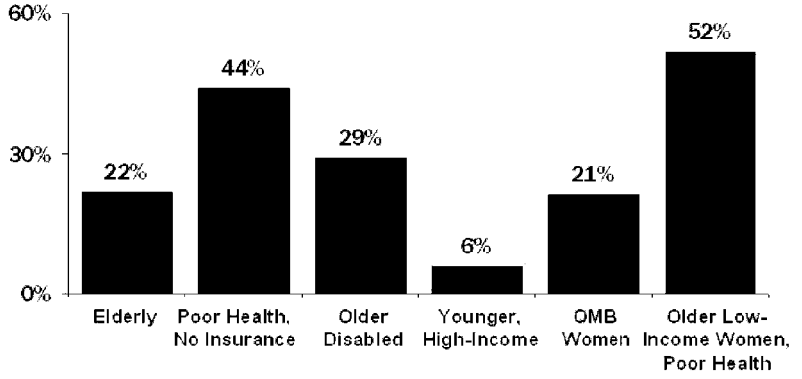
Medicare Beneficiaries Pay a High Percentage of Income for Health Care, 1996

Total health spending as a percent of family income



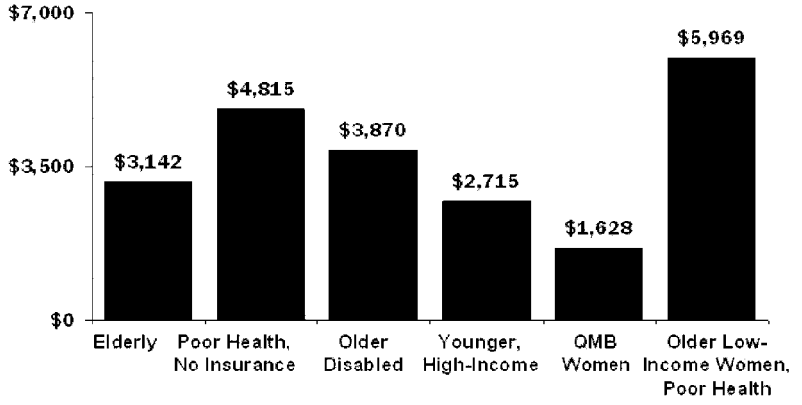
Source: M. Moon, C. Kuntz, and L. Pounder, Protecting Low-Income Medicare Beneficiaries, The Commonwealth Fund, December 1996.

Out-of-Pocket Spending as a Share of Income Among Cohorts, 2000



Source: Maxwell, Moon, and Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

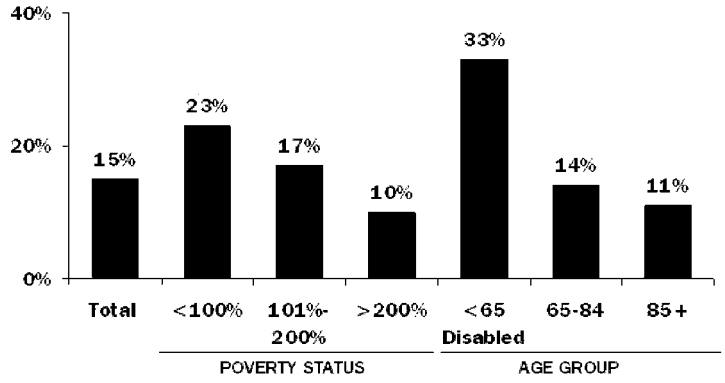
Per Capita Out-of-Pocket Spending Among Cohorts, 2000



Source: Maxwell, Moon, and Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

Difficulties with Access to Health Care, by Poverty Status and Age Group

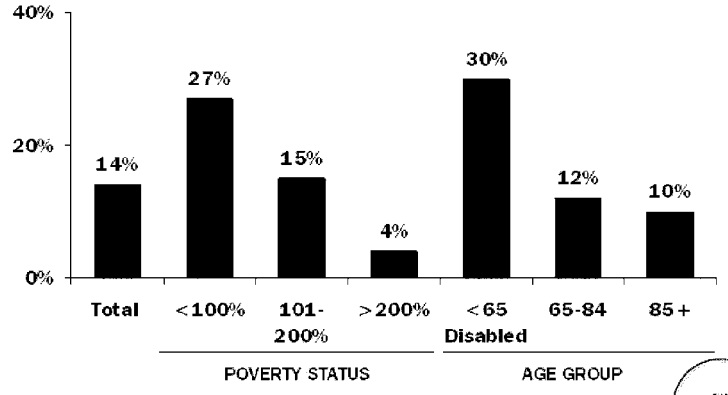
Percent of beneficiaries reporting difficulties with access to health care*



* Difficulties with access to health care refers to beneficiaries who either needed medical care but didn't get it, put off or postponed care, were unable to see a specialist when needed, or reported that it was extremely, very, or somewhat difficult to get care.
Source: Schoen, et al., *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.

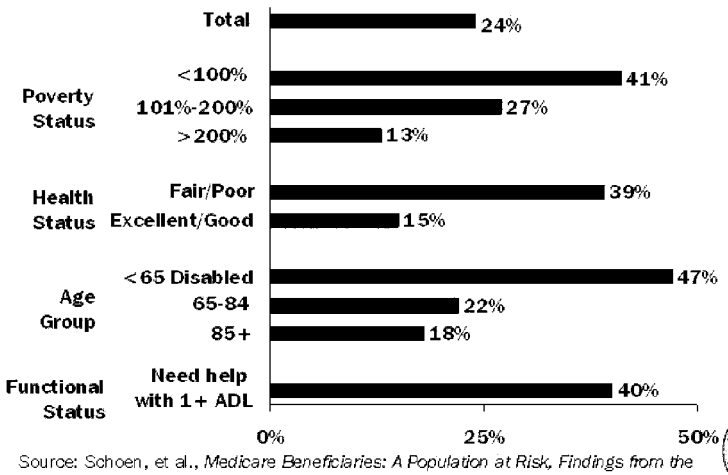
Problems Paying Medical Bills, by Poverty Status and Age Group

Percent of beneficiaries saying it was "very difficult" to pay medical bills or that they had spent all savings as a result of medical bills



Source: Schoen, et al., *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.

Medicare Beneficiaries Experiencing Access or Cost Difficulties, by Poverty Status, Health Status, Age Group, and Functional Status



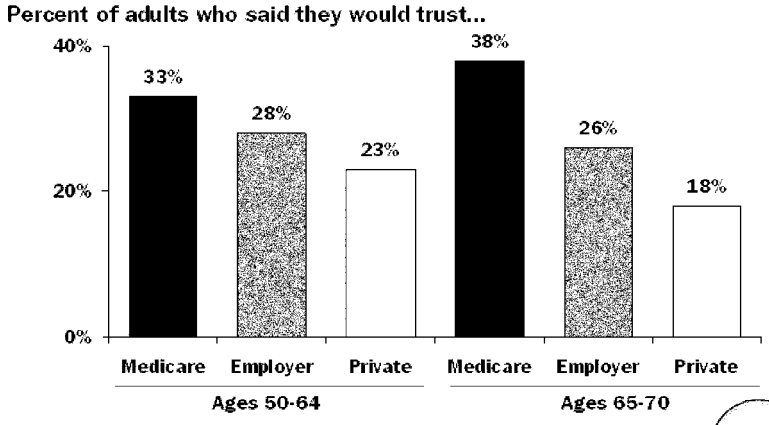
Source: Schoen, et al., *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.

Cost-Sharing in Employer Health Plans

- **The average deductible for all services in employer conventional fee-for-service plans is $239; $187 in PPO plans, and $79 in Point of Service plans**
- **The median maximum out-of-pocket ceiling in conventional employer plans is $1,500**
- **Physical exams are covered by 71% of firms; prescription drugs by 87%; dental by 25%**
- **The average monthly premium paid by workers for single coverage is $28, or $336 a year**

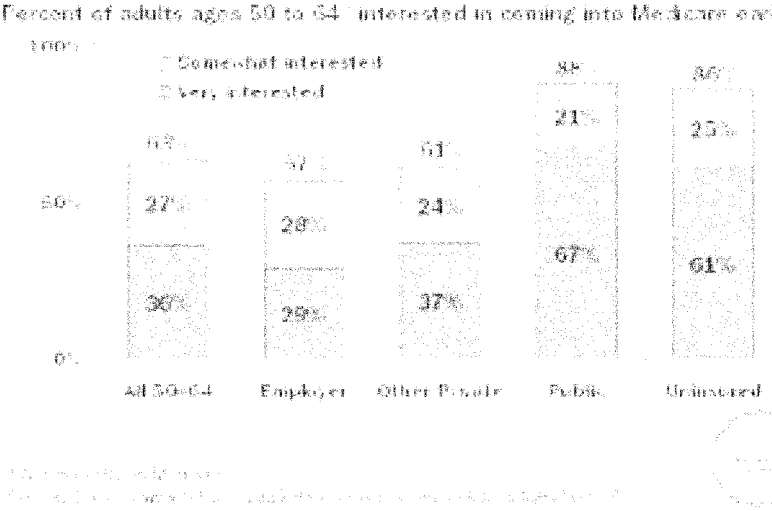
Source: Kaiser/HRET, Employer Health Benefits: 2000 Annual Survey.

Which Would You Trust More to Insure Adults Age 50-64?

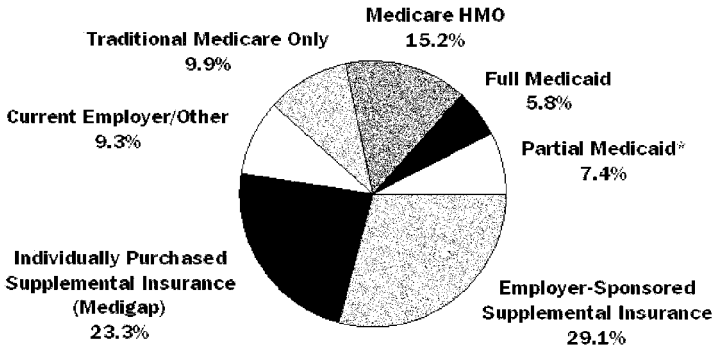


Source: Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.

Many Older Adults Are Interested in Getting Medicare Before Age 65

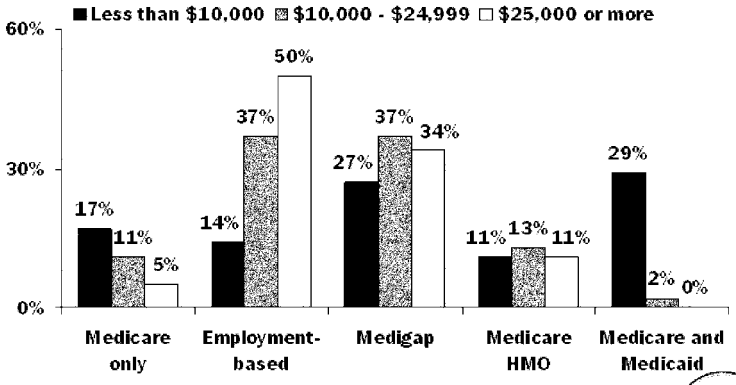


Distribution of Insurance Coverage Among Medicare Beneficiaries, 1997



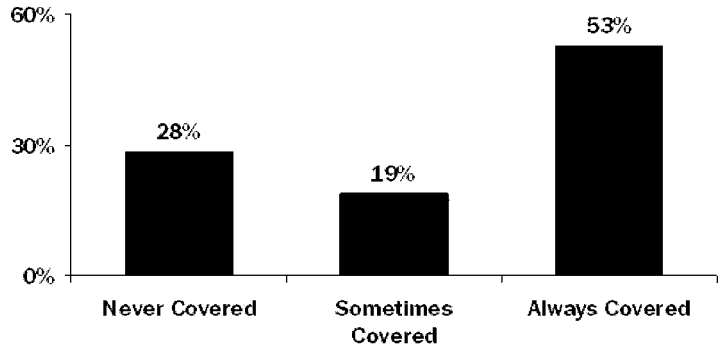
*Partial Medicaid refers to qualified Medicare beneficiaries and specified low-income Medicare beneficiaries.
Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

Percentage of Medicare Beneficiaries with Different Types of Supplemental Coverage, by Income, 1996



Source: Pourat, Rice, Kominski, and Snyder, "Socioeconomic Differences in Medicare Supplemental Coverage," *Health Affairs*, Vol. 19, No. 5, September/October 2000, p. 186-196.

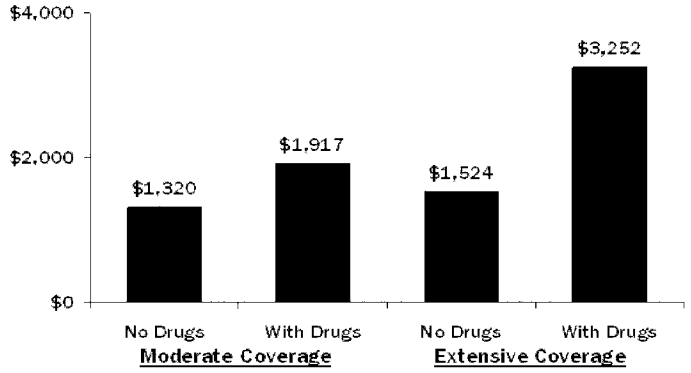
Prescription Drug Coverage of Medicare Beneficiaries in 1996*



*Noninstitutionalized beneficiaries enrolled in Medicare throughout 1996.
Source: Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, The Commonwealth Fund, January 2000.

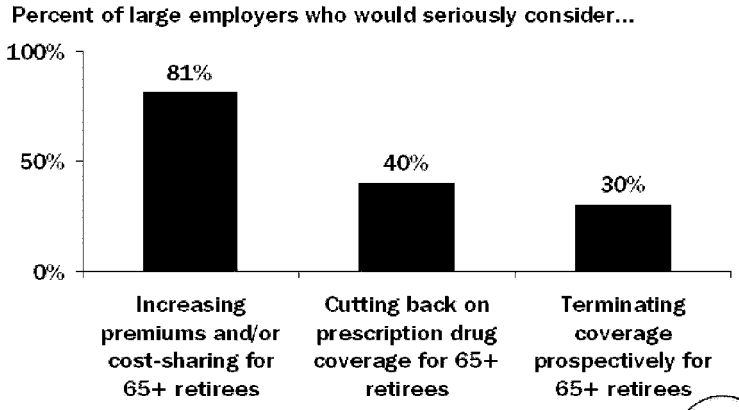
Supplemental Medigap Coverage Expensive With or Without Prescription Drugs

Average annual Medicare supplemental insurance quotes for a 65-year old woman*



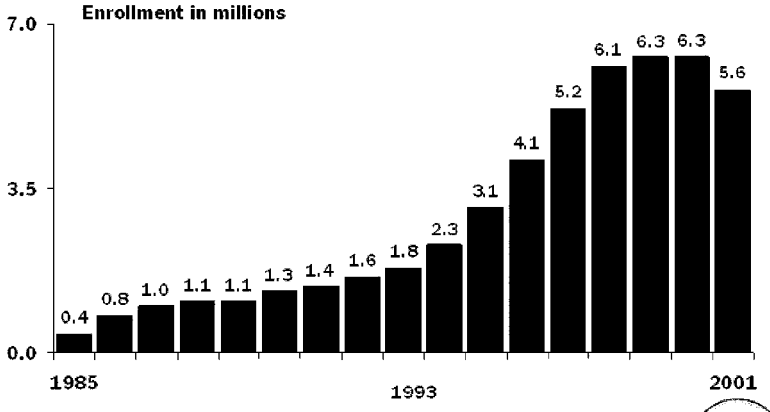
*Average of quotes from five counties: Butler County, KS, Multnomah County, OR, Sacramento County, CA, Dade County, FL, New York County, NY.
Note: Moderate coverage without drugs is Option E, with drugs it's Option H. Extensive coverage without drugs is Option F, with drugs it's Option J.
Source: Quotesmith.com as cited in Marilyn Moon, *Assessing the President's Proposal to Modernize and Strengthen Medicare*, prepared for the Commonwealth Fund, January 2000.

Large Employers Are Considering Restricting Retiree Drug Benefits



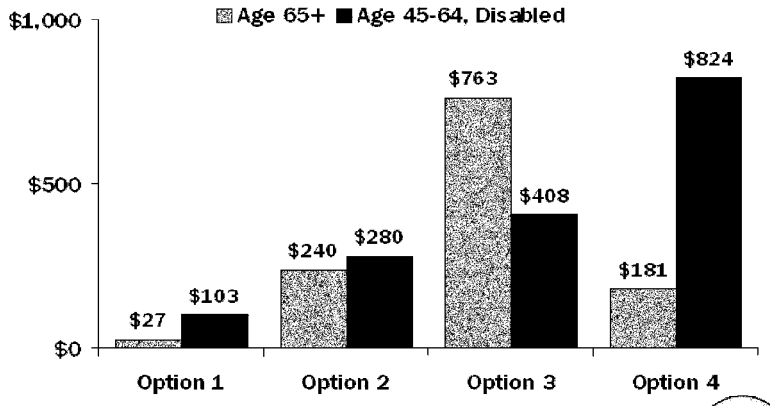
Note: Based on a survey of 600 companies with more than 1000 employees.
Source: McArdle, Coppock, Yamamoto, and Zebrak, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, Hewitt Associates, October 1999.

Medicare Risk/Medicare+Choice Enrollment, 1985-2001



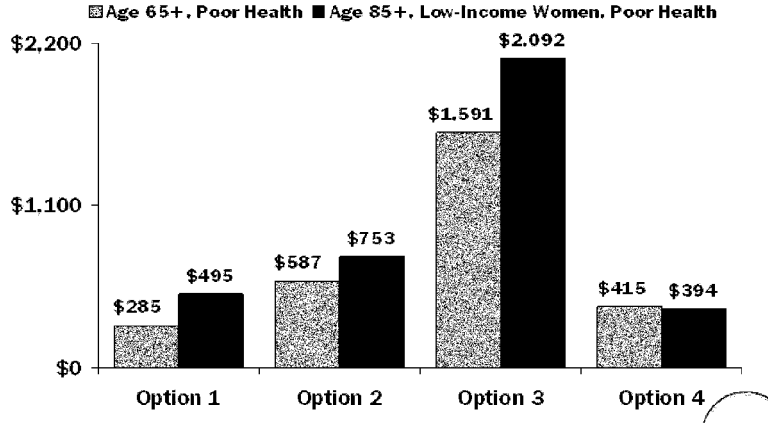
Source: Gold and Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare +Choice Health Plans, 1999-2001*, The Commonwealth Fund, April 2001.
Note: All data are for December of the year indicated except 2001 which is for January.

Savings in Out-of-Pocket Spending Under Four Options for the Elderly and the Disabled, 2000



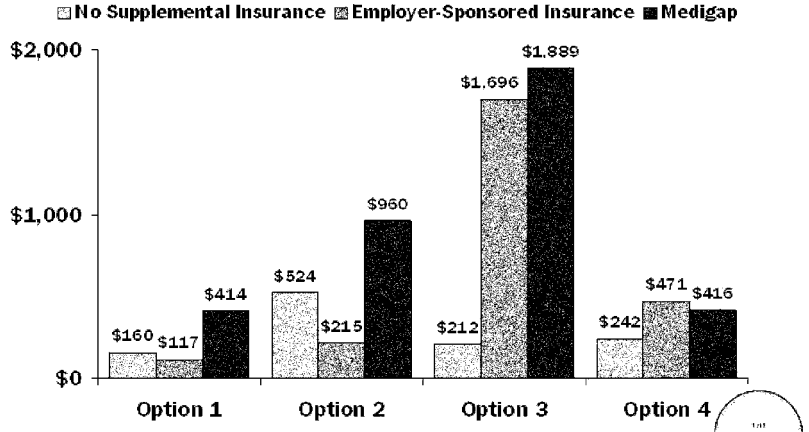
Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

Savings in Out-of-Pocket Spending Under Four Options for the Sick Elderly and Sick, Aged, Low-Income Women, 2000



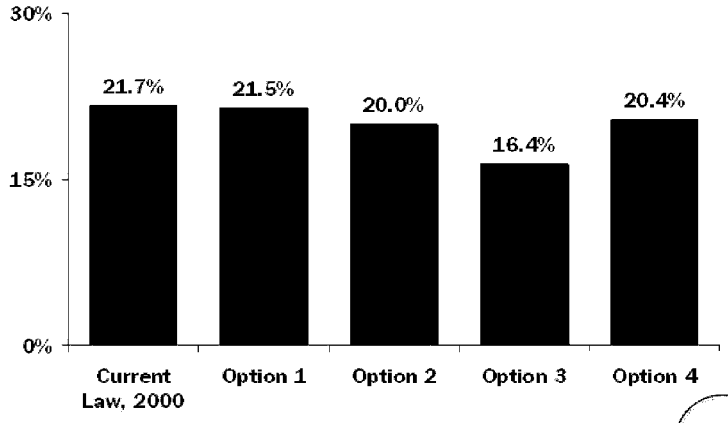
Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

Savings in Out-of-Pocket Spending Under Four Options for Elderly Beneficiaries in Poor Health, by Type of Supplemental Coverage, 2000



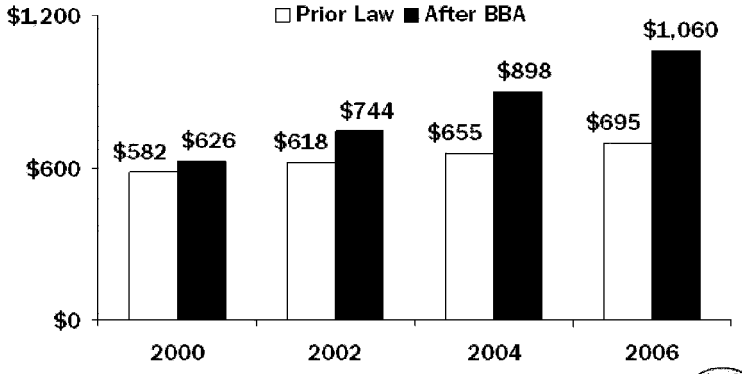
Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

Out-of-Pocket Spending as a Share of Income Among Elderly Beneficiaries, by Option, 2000



Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

Projected Annual Medicare Part B Premiums, 2000-2006



Source: Sandy Christensen, "Memorandum on Medicare+Choice Provisions in the Balanced Budget Act of 1997", Congressional Budget Office, November 12, 1997 and the 1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

Acknowledgements

- Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001
- Maxwell, Moon, and Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001
- Schoen, Neuman, Kitchman, Davis, and Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998
- Erin Strumpf: research and production
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Chairwoman JOHNSON. I thank the panel for their contribution.

Dr. Davis, you make the point that Medicare needs to be modernized both in terms of benefits, and you point to prescription drug benefits, and in terms of cost sharing. While I appreciate your com-

ments about what we have saved from Medicare, it is true that Medicare costs will double in 10 years. It is a very big program, and it is growing very rapidly. That is without prescription drugs or annual physicals or any of the other things that we ought to be doing to modernize the benefit package.

If this is your recommendation, how would you control costs? In the private sector, we just heard that 90 percent are in some form of managed care, but in Medicare, only 15 percent. What would you do to control costs if you are going to expand the benefit package and reduce cost sharing?

Dr. DAVIS. You are certainly correct, Madam Chairman, that Medicare outlays will increase as costs go up and as there are more baby-boomers retiring, but costs will also go up for beneficiaries so that the average amount beneficiaries will pay will go up from $3,000 to over $5,000 a person, and that is holding constant for inflation.

Chairwoman JOHNSON. Right. That is holding constant for inflation and no new benefits. So that has got to be of concern to us, but if that is a concern to us under the current program, what is it that you propose that might control costs so that this would be affordable, so that beneficiaries would not be harmed?

Dr. DAVIS. Right. The first thing I am saying is that we do not want to just shift more costs onto beneficiaries to protect the Federal budget. That will make the beneficiary situation worse.

We are all looking for the magic bullet that would achieve savings.

Chairwoman JOHNSON. We did use a few good ones.

Dr. DAVIS. The one that is proposed in this testimony is eliminating dual coverage by integrating that into one source of coverage.

Certainly, right now, Medicare's administrative costs run 2 percent a year. As we have heard from the General Accounting Office, Medigap administrative costs run 20 percent a year. One way to achieve savings is to cover those benefits under Medicare at a 2-percent administrative cost instead of a 20-percent administrative cost add-on. That would mean beneficiaries would be paying a premium, an additional premium to Medicare, but they would achieve savings by having no or lower Medigap coverage premiums.

So one source of efficiency is instead of having two plans covering the same benefits, having one plan integrated, under Medicare, a single premium being paid to Medicare, and realizing those administrative savings.

Chairwoman JOHNSON. All of that would actually increase costs significantly since Medigap covers new benefits. So, if you were going to merge those premiums, you would have to also merge the benefits.

So you really are obliged to give us some ways to control costs. The private sector has controlled costs by adopting a managed care protocol that, while it has some failings, has both better integrated care and, in many instances, responsibly controlled costs.

So I hear what you are saying about improving benefits and reducing the beneficiary burden, but without better research and recommendations in terms of overall cost control, we cannot be blind by the fact that the program is growing by leaps and bounds. In

only 10 years—that is before the baby-boomers will retire—the program will double, with no improvements.

Dr. Scanlon and anyone else who wants to pitch in on this, what is the research that demonstrates that deductibles have an impact on usage, utilization, and, therefore, cost? How much does that research tell us about that personal discipline over utilization? Does it eliminate needed care as well as unneeded care? What do we know about deductibles and cost control? Dr. Scanlon?

Dr. SCANLON. Madam Chairwoman, what we do know is that the absence of cost sharing does lead to a significant increase in cost. I think as Dr. Hogan's testimony points out in detail, studies have indicated that costs may increase as much as 25 percent when there is first dollar coverage because one has a Medigap plan.

When one has employer-based insurance, which still has reduced deductible, there is an increase in utilization compared to those without any supplement coverage at all, but it is less than having first dollar coverage. So we do know that there is a very positive increase in terms of utilization.

Being able to sort what are necessary services that are being used because there is no longer a financial barrier versus those which are discretionary or unneeded, is not something that has been possible to do.

We have done work in looking at other aspects of Medicare, in particular, looking at laboratory services under the End Stage Renal Disease (ESRD) program. We find where there is no cost sharing a totally inexplicable pattern of service use: extensive overuse as well as underuse. We had a panel of nephrologists review the tests that were being provided. In some instances, tests were being provided every week, and the nephrologist panel said they never understood why you would ever provide this kind of a test.

So the absence of cost sharing creates lack of discipline. Having cost sharing potentially creates some barriers. Finding the balance between those two is the challenge that we face.

Chairwoman JOHNSON. Thank you. Does anyone else wish to comment on that point? Is that what you mean, Dr. Hogan, by Medigap costing us $1,000 per beneficiary?

Dr. HOGAN. That is right. Once all of the copays and deductibles are paid, when care is free, beneficiaries will use more.

Chairwoman JOHNSON. You say that, but Mr. Stark in his opening statement did not agree with you. So you need to document that if you believe that is true.

Dr. HOGAN. Yes. If I wanted to point to some particular pieces of research, the Congressional Budget Office has their own studies. Joe Newhouse at RAND had the National Health Insurance Experiment in the eighties. It was an under-65 population, but it was a true experiment. They literally assigned people to different plans and looked at their expenditures and that found the same result.

I can guarantee you that every cost estimate you see for the cost of a drug benefit will have such an effect embedded in it, and every cost estimate comes out of the actuary's office and HCFA will have such a cost estimate.

I am kind of an agnostic on the whole concept of necessary care. I do not think that is the way decisions are actually made. It is not healthy beneficiaries who are using services frivolously. Most bene-

ficiaries have something wrong with them, and if you look at the services where Medicare pays the most money, Part B—Part B is what I know. I worked for the Physician Payment Review Commission for a number of years. Cataract surgery is the number-one service for which Medicare pays physicians. What is the indication for cataract surgery? Well, you have to have some loss of visual acuity. It is not a necessary or unnecessary decision. If you say to a beneficiary, "Now with current technology, cataract surgery is quick, painless, and has almost no complications," you say to a beneficiary, "We can fix your visual deficit and it is free" versus "We can fix your visual deficit and it will cost you $600 or $700," I think that is enough to deter enough people to at least think about it a while. So I just want to say I am an agnostic on the concept of necessary care.

You definitely find that people will use fewer preventive services when they have to have copays and deductibles, but they use fewer services right across the board.

Chairwoman JOHNSON. Thank you.

Mr. Stark.

Mr. STARK. Madam Chair, I would like to follow on that.

In your chart, Dr. Hogan, you suggest that you are using $5,000 per beneficiary per year, and then you are comparing and you are saying that with employer-based Medicare plus some kind of an employer base-sponsored supplement, you save 100 bucks, it is $4,900. With Medicare and a Medigap policy, you are suggesting the cost is $5,400. So that is $400 more. What you further say to get to that $1,000 savings is that those people with Medicare only, only costs $4,000, right? But you further said that that is only 10 percent of the Medicare beneficiaries, right? I think it follows that they are the very poorest of the Medicare beneficiaries, right, and least apt to have medical services available and, and, and, and. So that, I think that the idea of suggesting that these copays cost us 1,000 bucks may not be entirely based in the supplemental payments is what I am getting at. We are talking about 10 percent who arguably are the most challenged of our beneficiaries.

Further, we did not get into this. Dr. Scanlon, what is the average per-capita Medicare cost for the 40 million beneficiaries? Do you have a number off the top of your hat?

Dr. SCANLON. I think it is approximately $6,000 per year.

Mr. STARK. OK, it is 6,000 bucks. So Dr. Hogan used $5,000 just as an estimate here.

But if you take the $6,000 figure and take the Medicare Plus Choice, we have been told that if we risk the Plus Choice, we would be paying 7-percent less, so there is a $420 overpayment in Plus Choice. It certainly does not have any deductibles, I do not think, any Plus Choice. It may have some modest copays. But I am not sure that we can just capriciously suggest that a variety of charges tacked on hither and yon will save money that we want to save because, in none of these purely numeric calculations, I do not believe, any of our witnesses have talked about whether the savings came from unnecessary medical procedures.

You did not take that into account, did you, Dr. Hogan? You do not make a judgment here as to whether the difference in the

$4,000 for Medicare only was a savings of 1,000 bucks on services that were unnecessary.

Dr. HOGAN. In my written testimony, I point out it is, more or less, across the board. In fact, all of the five preventive services that can easily be identified in the current beneficiary survey are used less by the beneficiaries who have to pay their own copays and deductibles.

Mr. STARK. I guess you could get a fight in any bar in town as to whether or not preventive services are worthwhile and which ones we ought to be paying for, but this Subcommittee has added preventive services. We may all have a different list of priorities, but I think many of us have some we still do not pay for that we would like to add.

So all I would like my colleagues to consider in this is that while there can be some savings in ratcheting up copays or certainly in deductibles in going to the hospital for a day where it is $600 or $700 is that what we want to do? There are ways to save money, and we have got a whole litany of those, but I just want to urge us to be cautious that we do not eliminate necessary medical procedures and overlook unnecessary ones. I am not sure that just dealing with broad copays or Medigap does that.

I do not have any answer, but I just want to remind us that we could do some real harm here to people who need services.

Chairwoman JOHNSON. I certainly appreciate the barrier that copayments can cause, but that is why I asked Dr. Scanlon and Dr. Hogan and they did name off a number of research projects that have been done that demonstrate that deductibles do lead people to think about whether they need the service or not. In the employer sector or even actually in Medicare, there does not seem to be any evidence that deductibles have been a barrier to care.

Now, in Medicare, there are a lot of other barriers to care. So it is a little hard to make the comparison.

Why don't I recognize Mr. McCrery and see if others pursue this topic and can come back to it. I think the point is we really have to have better documentation on this issue of deductibles because it does seem to be a factor, and we need to understand what kind of factor it could be for us as we face governing a program whose costs are exploding.

Mr. McCrery.

Mr. MCCRERY. I appreciate the testimony and especially the references to other studies that have been done on the effectiveness of copays and deductibles in discouraging over utilization.

My own sense is, though, that discouragement is probably greater in the under-65 population than it is the over-65 population. The over-65 population, generally speaking, probably has more need to go for services than the under-65 population.

Having said that, though, I do believe that there ought to be some requirement on the part of beneficiaries to pay some copayment or some deductible. The question to me is finding the right balance between discouraging over utilization and discouraging proper utilization, and I have not heard any of you give us that magic formula today.

I was intrigued, though, Dr. Hogan, by your proposal or, I think it was, the AMA's proposal that you mentioned for a prepaid de-

ductible that they could get back at the end of the year if they did not use. Have you thought about what effect that proposal would have on the secondary insurance market?

Dr. HOGAN. Really, the point of that proposal is twofold. For better or worse, it works like a small medical savings account.

Mr. MCCRERY. Right.

Dr. HOGAN. But, mostly, it creates a little space where Medicare says for the amount that we are comfortable with, it might be a few hundred dollars, copays and deductibles shall apply, and the secondary insurers will not touch that. So the main point of it is to assert a small amount of money over which Medicare controls the copays and deductibles, not the secondary insurers.

Their Medigap premiums would fall because they would not pay that first few hundred dollars of copays and deductibles, but would not fall a whole lot because you have to realize there is an awful lot of money out there on the far tail of spending. There is a few catastrophic cases that account for most of the costs, but other than that, if they would make their packages conform to Medicare's new structure, they would simply take it in stride. They would have a new set of plans, A through whatever, and they would charge somewhat lower premiums to cover the amounts beyond that prepaid deductible.

Mr. MCCRERY. So, in other words, you would not allow secondary insurance to cover that prepaid deductible?

Dr. HOGAN. No. The whole point is you would not allow secondary insurance to cover the prepaid deductible.

Mr. MCCRERY. That is a very interesting proposal, Madam Chair, and I hope that we will explore that further. It might be that we could even encourage it by making it like an MSA (medical savings account) and making it pre-tax dollars to be put into the account, and it could be rolled over from year to year if they so desired.

Dr. Davis, you encouraged us to look at providing more services, prescription drugs, lower deductibles, and so forth, and it rang familiar. Isn't what you are describing very much like the catastrophic plan that Congress adopted back in 1988, I believe it was?

Dr. DAVIS. Obviously, the catastrophic plan was designed to improve benefits. It was designed to put a ceiling on total spending that the elderly would have to pay, and it did have a prescription drug benefit.

There are some significant differences. That particular proposal was financed by an income-related premium. That was a very sharp increase for beneficiaries that currently have employer supplemental coverage. So they saw themselves as getting no new benefits and, yet, paying a higher premium.

What is laid out in this report that we have released today are four options, one with prescription drugs, three to change the cost sharing. All of them actually would increase the Part B deductible slightly, up to $200 from $100. That is the one deductible that has not increased in real terms, but they would markedly reduce the Part A deductible.

One of the effects of that, for example, one of the options reduces the Part A deductible to $200. More people would be willing to do without supplemental coverage if they knew the most they had to pay for Part B was $200, the most they had to pay for Part A was

$200, and there was a total ceiling of $2,000 on any cost sharing and deductibles overall.

So, in fact, it is restructuring it, but the basic effect is to lower the average amount that beneficiaries pay as a percent of income across all services.

Mr. MCCRERY. Did your study estimate a cost of the proposal?

Dr. DAVIS. Yes.

Mr. MCCRERY. What was that?

Dr. DAVIS. There are cost estimates attached to those. If you think about, say, the year 2000 as a typical base, the first option increases Medicare outlays by about 2 percent, option two by about 7 percent, option three is budget-neutral. Obviously, if you were to do that, you would want to do participation rates, and you would want to do estimates over time and behavioral shifts, but there are estimates in percentage terms and in dollar terms. Option one is $3.2 billion in the year 2000; option two, 16.4. Option three is financed by increasing the Part B premium to $105 a month. So there is actually budget neutrality in that particular option, but there are cost estimates provided, to give you a sense of what these would entail.

Mr. MCCRERY. Thank you.

Chairwoman JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair.

Dr. Hogan, in your testimony, you indicated those folks with supplemental insurance or Medigap actually cost the Medicare Program on average about $1,000 more.

Can you point out specifically what services are being over utilized or where we are being taken advantage of or where the Federal Government is paying more?

Dr. HOGAN. I keep telling you folks necessary care is a fiction that physicians created. I do not think there is any such thing.

There are some clear-cut cases. There are some cases that are not clear-cut. Most medical care is kind of gray, and I do not think it is particularly profitable to talk about necessary and unnecessary care. Maybe "value" is the better word, whether the value of the services that you get with zero copay is——

Mr. KLECZKA. But if, in fact, you are going to contend that on average, we are spending for the program $1,000 more, I would think that at least you could pinpoint where. Is it just doctor's visits?

Dr. HOGAN. Oh, no, no. If you look at the research, the research shows that the impact is much higher on the B side than on the A side. So it is not the hospitalization. That is the typical research.

Mr. KLECZKA. So with physician's visits, OK.

Dr. HOGAN. Right. So it is physician visits and tests and procedures and images. That is where the largest dollar impact is.

If you go back to the national health insurance experiment, which is the under-65 and it is old, Joe Newhouse found that when you charge copays and deductibles, their utilization fell mostly, again, for physician services, but it did not seem to affect their health status as far as he could tell with some important exceptions, and the exceptions were pretty obvious once you saw them.

Poor people with mental health problems: If you charge them copays and deductibles, their health deteriorates. So there is a bit

of research to tell you where you should not charge copays and deductibles, and poor people with mental health problems is one of them.

Beyond that, doctors cannot tell you what is necessary and unnecessary. You certainly would not want to ask an economist to tell you that.

Mr. KLECZKA. But if I were a doctor, I would want to do more versus less because medicine is an imprecise science, and so, if I am trying to do a decent analysis of a patient, I am going to have to maybe do another test which you say if it was not for this Medigap policy, this doctor would have done it, anyway. It gets kind of murky and cloudy.

This is an interesting discussion, and I guess it is a rhetorical question. However, what I am wondering about is what is the actual purpose of copays. Is the purpose of copays and deductibles to have the patients share in the cost, or is it to try to restrict utilization, or is it a combination of both? If it is an effort to restrict utilization, then the answer for this Committee and the Congress is raise those copays and people just will not go. So, in your view, Ms. O'Sullivan, what are we trying to accomplish with copays and deductibles?

Ms. O'SULLIVAN. It is essentially a combination of the two.

Mr. KLECZKA. That is what I was afraid of.

Ms. O'SULLIVAN. You are trying to make beneficiaries cost-conscious at the point when they use services, but not make the cost sharing so high that they will forego needed services and then perhaps incur larger expenditures down the road.

Mr. KLECZKA. Do you agree with Dr. Hogan's contention that because of supplementals and Medigaps that we are under a Medicare Program paying about $1,000 more?

Ms. O'SULLIVAN. There is research that shows that Medicare beneficiaries that also had Medigap policies do cost the Medicare Program more.

I think you should remember that people who buy Medigap policies are buying a policy that they know is going to cover most, if not all, of their cost sharing, and they probably purchased a policy based on the expectation that they are actually going to need covered services. So there is some of that entering the picture, also.

We know that people that have employer-based policies cost Medicare more. They cost about 10 percent more than people that have no coverage. Arguably, people that have no coverage are the people that are low income, but above the Medicaid line. So any cost sharing could seem fairly burdensome to them. For them, cost sharing has a fairly big implication for them, and they may well be foregoing services that they actually need.

The other comment I would make is when you are talking about impact of change in cost sharing, we do not have one supplementary market out there. We have Medigap. We have the Qualified Medicare Beneficiaries and the Specified Low-Income Beneficiaries (QMB/SLMB) populations for whom Medicaid is paying Medicare's cost-sharing charges. We have employer-based policies which have various ways of wrapping around Medicare, and we also have Medigap and there are 10 of those. So any tweaking of Medicare will have differential impacts.

Mr. KLECZKA. Fine. Thank you.

Chairwoman JOHNSON. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chairwoman, and thank you for calling this important hearing on Medicare beneficiary cost sharing.

I am concerned like you, Madam Chair, about the costs that beneficiaries must pay when they get sick, the plans they must purchase to cover their needs because of Medicare's copays and the lack of catastrophic coverage, and, of course, I am also concerned about the fact that this problem is really exacerbated because Medicare lacks catastrophic protection. That is contrasted with 97 percent of private health policies which have such protection.

So I think in total, when you look at Medicare's limited benefits package, it is high copays, and the complete absence of catastrophic, that means that nearly half of our seniors' health care costs are not covered by Medicare. That practically means that Medicare seniors must bear the cost themselves. This fact of lack of coverage is unacceptable and needs to be addressed through our comprehensive reform.

In that vein, I would like to ask you, Dr. Scanlon, first, does the status quo in Medicare cost saving make sense to you when compared to private-sector health insurance plans which structure, of course, are out-of-pocket obligations?

Dr. SCANLON. No, sir, they do not.

Clearly, as you indicated, the lack of catastrophic protection is something that private insurance does not have, and it is sorely lacking in Medicare. It creates a situation where we do not really have a true insurance policy. You can be catastrophically harmed by your medical expenses, and that is something that we would hope for as the first thing to accomplish in a Medicare reform.

Second, what has happened is over time, the cost sharing that was put into place in 1966 and has been modified, as Ms. O'Sullivan indicated, only slightly since then has evolved in ways that distort it even further than what it was before.

We did not expect in 1966 hospital costs to be growing so much so that the deductible would be close to $800 today, so that a single hospitalization alone creates a large expense for individuals.

We have not seen the Part B deductible keep pace with inflation. So it is withering in terms of the share of real income that it represents.

These are not the kinds of things you would see in most private insurance plans because they have been adjusted over time to try and reflect the changes in medicine as well as the changes in the cost of medicine.

Mr. RAMSTAD. Dr. Scanlon, I think your summary statement says it all when you said that Medicare beneficiaries do not really have a true insurance policy. That should concern all of us on this panel, as I know it concerns so many people in the Medicare system.

Let me ask you, Dr. Hogan, if you will, please. In your testimony, you stated that the current Medicare supplemental system is, to use your words, regressive and disproportionately affects the poor. Could you just expand on those comments?

Dr. HOGAN. I will not say it is the worst of all possible worlds, but beneficiaries who can most afford to pay the copayments do

not. They buy Medigap. The beneficiaries who cannot afford to pay the copayments cannot afford Medigap, and those who can afford Medigap drive up costs for everyone, including the Part B premiums that poor people have to pay.

So I could think of two reasonable approaches. Either make it free for everybody or make everybody pay, but allowing the working stiffs who do not have a decent job and do not have decent employer-sponsored coverage have to pay those copayments, those irrational copayments out of pocket, and everybody else has enough money to buy Medigap. That is not sensible.

Mr. RAMSTAD. I thank you for that very honest and, I think, accurate response.

I think oftentimes a statement made earlier this year by our colleague working on Medicare reform on the Senate side, Senator Breaux, who said right now what we are doing with respect to the Medicare system is analogous to putting gasoline into a 1965 Chevy when, in fact, we need a new car, and I think all of you would agree to that statement as to the need for overall comprehensive Medicare reform.

I thank you for your testimony here before the Subcommittee, and your continuing counsel is definitely appreciated. Thank you, and I yield back the balance of my time.

Chairwoman JOHNSON. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

I want to thank the witnesses for being here today and giving us some information here.

I go through this every time we have a group before us. So you guys kind of need to help me here. If a Medicare beneficiary chooses to enroll in a Medicare Plus program, he or she then does not have to have a Medigap coverage. We all know that because they have no deductibles. They have maybe some co-payments.

Then, in an article—and I just kind of would like your all's opinion about this—published in Health Affairs in January 1999, Gail Wilensky and Joe Newhouse suggested—and I will quote them here—that, "In an informed program, additional benefits should be provided through the Medicare Program and not through a Medigap plan." In other words, my understanding of this is to create a level playingfield between traditional Medicare and Medicare Plus Choice plans, Medigap should be merged into traditional Medicare fee-for-service plans so that the Medicare beneficiaries would not have to purchase separate Medigap insurance.

So the question is do you agree or not agree with that summary, and if so, why, and if not, why. I will ask all four of you that question.

Dr. DAVIS. I certainly have a lot of agreement with the idea that Medicare benefits ought to be improved to the extent that people would not need to buy Medigap. So that means covering prescription drugs, which is covered in most Medicare Plus Choice plans. It means getting the deductibles down to modest amounts that people can afford to pay without filling in, and to really have a modern benefit package.

We talked a lot about employer plans. The typical employer conventional fee-for-service plan has a $239 deductible across all services. Medicare has far more than that. It has a $1,500 ceiling on

a lot of out-of-pocket expenses, and that is for conventional fee-for-service. For their preferred provider plans, their point-of-service plans, those amounts are lower. So I think modernizing Medicare's benefits means you do not have to buy supplemental.

People with employer coverage do not go buy supplemental coverage. The fact that 90 percent of Medicare beneficiaries have to go buy something else means that what they have, they certainly perceive as inadequate. I think there are, as I have mentioned, efficiencies to be gained by simply consolidating that benefit within the Medicare Program.

Mrs. THURMAN. And just to add to that, I would further think that it puts everybody then on that level playingfield. Right now, we have so many things going on in Medicare, quite frankly, that just because of where your geographical location is does not give you the same benefit even though the payment is coming still directly from the government.

Dr. Hogan.

Dr. HOGAN. While I agree with the sentiment of that, there are a few little details. I only say this because I used to work for Joe and Gail. I was on the staff of one of their commissions, and there are a few little details you have to keep in mind. How much are you going to charge for the Medicare-sponsored Medigap policy, and are you going to pay less if you do not have it? If you add the Medigap premium to my $1,000 cost estimate, there would be almost $2,000 difference between what you would want to have, a beneficiary with no supplemental insurance pay and a beneficiary who has the Federally sponsored Medigap pay. So there may be a premium attached to that, that might be kind of unpleasant to look at.

The second issue is what about the people who have employer-sponsored coverage now. How are you going to make their employers continue to pay for that coverage, or are you just going to let them skate and have the taxpayers pay for it? So it is not as easy as you might think.

Nevertheless, what Karen said is exactly right. You would certainly get some efficiencies just from the overhead alone rolling Medigap into the Medicare program because their overhead charges are lower, and it is a lot easier for Medicare to run the individual purchase policy than it is for the private sector to do it.

Having said that, this sentiment is correct, but there is a devil in the details that you really have to pay attention to.

Dr. SCANLON. I agree, and I think there is a rationality to improving Medicare so that the need for a Medigap policy declines.

There is a reality today that there is a rational need to buy catastrophic protection. It is somewhat irrational to be buying first dollar coverage. Essentially, what you are doing is for that first $100 of medical care that you are going to use, you are paying someone $120 to write that check. That does not make a lot of sense.

So the idea of incorporating these types of protections into a better Medicare program and offering it to beneficiaries, I think, would reduce the need for Medigap.

Mr. Stark indicated, also, we have a very complex system that has developed here in terms of the different participants and that

we would be creating some very significant disruption in terms of making a change like that.

Mrs. THURMAN. But aren't we creating some problems out there with the Medicare population, anyway, because their benefits are so different depending, again, whether they can have prescription drugs, whether they can have eyeglasses, whatever other procedures, and in Medicare Choice, really catastrophic? I mean, they have a catastrophic payment, and that is us.

Dr. SCANLON. We definitely are.

Our problem is we sometimes have trouble making the transition to a new system. If you look at the statistics on Medigap policies fully, a third today are policies that existed before 1992, many of which have much poorer coverage than the policies that are available today.

There may be issues of people not being able to get access to these benefits because of health status, but a full third are those are in older policies which have relatively limited coverage.

Ms. O'SULLIVAN. Certainly, one advantage of expanding Medicare's benefits would presumably make it more in line with the coverage people are used to up through age 65. Now, when they transition to Medicare, they are faced with a whole new set of requirements. So, from that perspective, it could potentially be easier for the population. Obviously, of course, this is a much more expensive population group than the under-65 population, and also, as has been mentioned here, you have to think of what the implications are for people with employer-based policies, would they just wrap around to the new Medicare coverage. Presumably, it could potentially be cheaper for some of the employers, though we also know a lot of employers who are getting out of the business of retiree coverage, anyway. So whether this would speed it or slow it down is a question you could ask.

But, yes, there are certainly some advantages. So, obviously, it has many implications when you flesh out the details.

Chairwoman JOHNSON. Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair.

Since we have such a distinguished panel—I read a news report just a couple of days ago or maybe yesterday about a study that was done recently that indicated that seniors are in better health than they used to be, basically, and that because they are in better health, they are costing less and that that might have fairly significant, positive consequences for Medicare spending in the out years. Did you all see that report, and do you have any comment on it?

Dr. HOGAN. May I be the first to jump in here?

Mr. MCCRERY. Sure.

Dr. HOGAN. Ken Manton, who did that report, is a well-respected demographer, and if he says it, I imagine it so. I certainly have not seen that come through in any statistics that I look at, but I do not look at a long-time series.

The only point I really want to make is this.

Mr. MCCRERY. I am from Louisiana. If you would talk just a little slower.

Dr. HOGAN. I am sorry, and I need less caffeine.

Jim Lubitz, years ago, did a study. Jim Lubitz is a researcher at the Health Care Financing Administration and did a study of bene-

ficiaries' lifetime spending. What you find is the longer you live, the more you cost Medicare, period.

Mr. MCCRERY. All right.

Dr. HOGAN. You will spend less in the last couple of years of life, but extending lifespan or coming in a little bit healthier and living a little bit longer, it is arguable that that will reduce. Even if it is true, it is arguable that that will reduce costs.

Dr. DAVIS. I do think it is a very important study that the National Academy of Sciences has published showing that disability rates of the elderly have dropped markedly from 1982 to 1997. If you really break it down by the kinds of conditions, you do see that we have had a major reduction in strokes over that period and much better control of hypertension over that period, breakthroughs in treatment for heart disease over that period. There is another major study supported by the Lasker Foundation that really looks at the benefits to the economy of that improved health, particularly in the last half of the 20th century that comes from these kinds of improvements, both in preventive care and breakthroughs like beta blocker treatment for heart attack victims.

They argue that the gains to the economy in the last half of the 20th century from these advances in health care equal the gains that have come from increased productivity over that period. So they really are quite significant. It is not just a matter of looking at how they affect Medicare spending. The longer we live, certainly there are going to be more years that we are on the Medicare program. That is, in part, the goal. The fact that we are improving life expectancy, we are reducing disability, I think it is quite significant.

I think it plays in today's discussion in the following way. When you talk about cost sharing, we have emphasized preventive services like getting mammograms or Pap smears or colonoscopies, but it is also important to have chronic conditions well maintained.

If you have got hypertension, if you have got diabetes, if you have got high cholesterol or arthritis, you need to be making regular visits to physicians. Many times, you need to be on a prescription medication to control that condition to avoid these adverse consequences of strokes and mortality from heart disease or disability from heart disease.

So, if you deter people from getting proper maintenance of chronic conditions—we supported, for example, a study that showed that people without supplemental drug coverage are much less likely to get hypertensive medication for people with hypertension than those that have supplemental drug coverage. So these issues of cost sharing and supplemental coverage and the quality of the benefits do affect these issues of life expectancy, disability, and quality of life.

Mr. MCCRERY. Dr. Scanlon.

Dr. SCANLON. Yes. I think the studies indicate some of the very positive things that have happened with medicine over the last 30 years, and that is part of why we are so concerned about getting people access to health care.

Dr. Hogan's comment about the lifetime expenditures, we do not know how that is going to work out yet because we have a new cohort of people who are aging with a very different life history than

the cohorts of the past—better nutrition, better medical care, different lifestyles—and we will wait to see how that happens. That is the positive side.

In terms of your question of how much relief this provides us, it may provide some relief in terms of per-capita spending, but as I have heard others say, it is not the per capita that is our problem. It is the capitas. It is when those baby-boomers come and they multiply whatever per-capita amount we are going to spend. That is the challenge, I think, that we are overwhelmed by.

Mr. MCCRERY. Ms. O'Sullivan.

Ms. O'SULLIVAN. I would agree with Dr. Scanlon.

Mr. MCCRERY. Madam Chair, it was a very interesting summary of the study that I read, and it might be that ina future hearing, we would like to bring in the authors of that study and others on the panel that might want to comment on the study. It would be very interesting for this Subcommittee to investigate.

Chairwoman JOHNSON. Thank you.

Let me ask the panel one final question. If you added the deductibles and the premiums under Part B or I guess you would probably want to exclude the deductibles since Medigap covers that—I mean, I am impressed that so many of my seniors are paying Part B and also Medigap premium. The Medigap premiums right now are pretty steep. They have gone up considerably.

So, if you just took the two of those and made them the deductible, then the out-of-pocket expenditure—I mean, I am not really proposing this. I just want to get your opinion. This is what seniors are spending now, a big chunk of them. If they spend it in a different pattern and if instead of spending it for premiums, it was a deductible or it was some kind of prepare bank account like Dr. Hogan proposes, then what would be the impact? Would you get the benefits of first dollar expenditure thinking? On the other hand, the exposure would not be any greater? See, if you do that, there are some advantages for low-income people, just above the levels that we now subsidize. You could subsidize those premiums, but that is, in fact, what seniors are spending now. If we are going to merge these and rationalize the program and broaden its coverage, then what would be wrong with broadening the deductible to cover, in a sense, what they are already paying and turn it in from a premium to a deductible and subsidize the premium for people in that group that now cannot afford either? That is one way. Would that have any impact on cost, Ms. O'Sullivan?

Ms. O'SULLIVAN. I believe your proposal is saying basically you take the Part B premium which is $600 a year and you would be adding to that an average Medigap premium which is $1,300, $1,500 a year. So you would be talking something——

Chairwoman JOHNSON. Except the Medigap premium usually pays the Part B premium.

Ms. O'SULLIVAN. No. No, it does not. It is separate.

Chairwoman JOHNSON. Or, just the deductible?

Ms. O'SULLIVAN. It is separate. So you would be talking something close to $2,000 as a deductible.

We know that beneficiaries, regardless of how you present something to them, are very risk-averse, and they do not want to be lia-

ble for even that first dollar coverage. Many of them might view the $2,000 as a very large gap before the program——

Chairwoman JOHNSON. They might, and I understand the fear issue, but they would not have any monthly payments.

Ms. O'SULLIVAN. Correct. The issue would be it would have to be presented, I believe, in a very simple form to be understood by everybody and people would have to understand what the tradeoffs are and you would probably also have to think about the implications of the people on the lower end of the income scale.

Chairwoman JOHNSON. Oh, you certainly would have to think about that, no question about that, but it is sort of interesting to contemplate. You have got a lot of people out there putting a lot of money out and not getting much for it, frankly, except peace of mind. Peace of mind is worth a lot, but it is not buying medical care.

Dr. Scanlon.

Dr. SCANLON. You do need to look at all of the sources of cost to the elderly, but you do need to break up these, the Medicare beneficiary population into the different groups because they are having very different experiences right now.

Those that are paying the Medigap premium are about a quarter of all beneficiaries. We have got more than a third who have employer coverage, and they are paying more in premiums today than they used to in the past, but they may be paying much lower premiums.

We have the people in Medicare Plus Choice plans. They are paying more today than they used to, but they still may be paying a lot less.

Then, finally, we have those who are Medicaid-eligible. That is a key part of this equation that you are thinking about in terms of how do you balance a restructured cost-sharing framework with affordability while avoiding negative impacts. The Medicaid dual eligibles and the QMB program provide you one of the mechanisms that you have already in place to think about how to protect people with lower income.

Chairwoman JOHNSON. Yes. The reason this is very important is that, as you say, there are different populations with different coverage. There is a third that has pretty good coverage, not just for prescription drugs, but for a lot of things that Medicare does not cover. Then there is this other third with Medigap who are paying an awful lot of money and, for the most part, not getting much in terms of prescription drugs. Then you have the ones that are Medicaid-eligible, as we say in our slang down here, SLMBs and QMBs, but they get everything for the most part. Some of them pay a little premium, but they are pretty well cared for and covered.

So you have then the group just above 100 percent of poverty income, and people in that level of income that can afford Medigap insurance, in a sense, they are the worst off. They have the Medicare-only plan. They have the Medicare premium of about $50 every month, and they have all the copayments under Medicare. If you look at all of the prescription drug plans, regardless of which party they originated from, they provide the least help to that very group because the other groups would have plans that would wrap around the help that is provided. So they will all do better under

a prescription drug program, but the group that has the least will pay an additional premium which they can ill afford, and then they will get 50 percent of their cost of drugs up to $2,000. This is not a big benefit in today's world of drug prices.

So I hear, Dr. Davis, your concern for the beneficiary cost issue, but I do not see the solutions directing themselves to the beneficiaries who right now have the highest costs with the least means, and I do not see how you can, frankly, in good faith deal with their concerns fairly and honestly and provide retirees with comfortable incomes the same benefits.

I do not think it is outright fair that my husband and I would have the same catastrophic level of coverage that I think many of these seniors need, which I think is about $1,000. I do not even know where some of them would get $1,000 to meet the catastrophic coverage, but many seniors we are most concerned about will never meet the threshold, the $4,000 catastrophic coverage. So I am very concerned that we talked blithely about helping the beneficiary, but the group that is least helped by any of these plans is the group that is least helped by any of the reform proposals unless you take Dr. Davis' that is very much richer in every, every case, but, frankly, I think would be unaffordable.

I will look at your cost estimates, but I cannot imagine without some means testing that you could do all the things you want to do and have no disincentive to buy because there is too much evidence in every market, employer-provided market, every market that people buy more health care than they actually need.

I will look more closely, and I will help the Committee look more closely at the evidence of the discipline of first dollar coverage. I think we absolutely are obliged to look at that and any other proposals you can think of to help us look at cost discipline because the more we rationally govern costs, the more we can help those who need it most to have the resources to get a fair and reasonable health plan.

If you have any closing comments, you may comment. Otherwise, we will close the hearing.

Dr. DAVIS. Just to stress that all of the options I laid out are not first dollar. They all have at least a $200 Part B deductible.

Chairwoman JOHNSON. Oh, yes. I am sorry. I forgot that. I was glad to hear that.

Dr. DAVIS. A Part B deductible of $200, which is the typical employer plan, but I think the idea of charging a $2,000 deductible for beneficiaries, two-thirds of whom are either very sick and paying an awful lot of money already or have very modest incomes below——

Chairwoman JOHNSON. But you could not do it outright.

Dr. DAVIS. Twenty thousand dollars is just not an affordable kind of benefit package.

Chairwoman JOHNSON. What I guess I am suggesting is if you think of what are currently paid as "premiums," as instead a kind of savings account, that if you did not use it all, you could roll it over for future expenses, we need some creative thinking, and that would functionally be a higher deductible, but it would be paid out like a premium into a savings account.

Anyway, we will talk about these ideas, and I hope you will all think about them because we do not really have the ideas that we need yet, and I hope you will be a part of generating them. I think the old way of linear thinking, sort of using the old employer model, is for this population not very useful because the costs are so extraordinarily variable and we are insuring people now, so very many years, with varying different means and capacities to participate in the costs themselves, and also with an urgency to keep in the market a variety of solutions, the employer solution, the choice solution, as well as a decent fee-for-service plan.

I hope you will draw from this hearing that we are really at the beginning of the road, and we are really not toward the end.

Thank you.

[Whereupon, at 3:37 p.m., the hearing was adjourned.]

[Submission for the record follows:]

Statement of the United HealthCare Insurance Company

The United HealthCare Insurance Company (United) is pleased to provide the Subcommittee with this written statement to supplement the transcript of the Subcommittee's May 9 hearing on modernizing beneficiary cost sharing in Medicare. The United HealthCare Insurance Company underwrites Medicare Supplement Insurance plans provided to AARP members through AARP's Health Care Options program. The views expressed in this statement are solely those of the United HealthCare Insurance Company and are not necessarily the views of AARP.

Medicare cost sharing is an important issue. Over the years, beneficiaries have been asked to cover an increasing share of their health costs. Today, Medicare covers roughly half of a typical beneficiary's health care costs, and it is likely that this proportion will continue to decline.

To remain viable, Medicare has relied upon supplemental coverage from a number of sources, including employers and Medicare Supplement carriers. Without this supplemental coverage, many seniors would not be able to meet their cost-sharing obligations.

Roughly one third of Medicare beneficiaries have a Medicare Supplement policy. For many beneficiaries, particularly in rural areas, Medicare Supplement policies are the only available supplemental insurance option. Therefore, it is extremely important that Congress consider the impact upon Medicare Supplement of any potential legislation to reform or modernize Medicare.

Issues for Consideration

In reviewing the supplemental insurance market, Congress should consider whether to revise the existing standardized benefits and whether there are ways to make supplemental insurance more affordable and accessible to beneficiaries.

Standardization was intended to provide consumers with a common set of benefits around which carriers would compete based upon price and service. Ten years of experience, however, has shown that standardization has not achieved all of its original goals.

First, although there are ten plans, only a few are frequently purchased by consumers. This suggests that some of the benefits need to be reexamined in light of the existing market and changes that have been implemented in Medicare.

Second, premiums have increased substantially, primarily due to medical inflation and additional requirements placed on Medigap carriers, such as coverage for beneficiaries under age 65. At the same time, many carriers have switched to attained age rating, a pricing system that raises premiums annually based solely upon age. To ensure that fee-for-service remains viable, Medicare Supplement plans need to be affordable for seniors of all ages.

Finally, since standardization, most Medicare Supplement carriers have imposed substantial medical underwriting requirements, excluding many people with high cost health conditions. At the same time, recent changes in guaranteed issue rights have created an extremely complex set of requirements that are almost impossible to administer. Underwriting requirements and guaranteed issue rules should be ex-

amined to ensure that Medicare Supplement plans are as widely available as possible.

Options for Reform

There are a number of reform options that Congress should consider in examining the Medigap market. First, because only a few plans are popular among consumers, Congress should consider combining existing plans and adding new benefits that consumers want, such as alternative medicine.

Similarly, Congress should review the prescription drug benefit in plans H, I, and J. Despite consumer desire for prescription drug coverage, these plans are not as popular as the non-drug plans. Moreover, most companies do not offer the drug plans in many areas. United is the only carrier offering at least one of the three drug plans in every state and, as a result, sells roughly half of all Medicare Supplement drug plans in the country.

Second, Congress should consider standardizing the rating methodology by which carriers establish premiums. Although standardization was intended to simplify the market, multiple rating methodologies are confusing to seniors and, particularly with attained age rating, create market incentives that actually disadvantage seniors. A uniform rating methodology would help accomplish one of the original goals of standardization—competition based upon comparable prices, value, and service.

Third, Congress should consider options that reduce premiums and utilization, such as co-pays and additional deductibles. Although these low-cost options should not be in every plan, they could provide broader benefit choices for people who want to reduce or minimize their monthly payments.

Finally, Congress should consider other reforms designed to reduce premiums and increase benefits to consumers, such as standardizing enrollment and other regulatory requirements, implementing "speed to market" measures that reduce administrative burdens on states and insurers, and allowing standardized plans as additional options in waiver states.